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PSYCHIC DETERMINISM AND RESPONSIBILITY*

BY LAWSON G. LOWREY, M. D.

As a clinical psychiatrist whose first scientific training was in anatomy and pathology, I was both surprised and pleased at an invitation to speak before the Guild of Catholic Psychiatrists on "psychic determinism," a formulation belonging in conceptual fields quite different from those which ordinarily concern me. Another reason I have for being pleased is that I was forced to make some very wide excursions into philosophy and metaphysics, theology and morals, which I might not otherwise have found the opportunity to do. I think, at least I hope, that I gained considerable insight into the polemics and semantics involved in what superficially appear to be some irreconcilable differences. There seems to be opposition not only in opinion, but in concepts as well.

Early training and psychiatric experience conditioned me to try always to ascertain the scientific and clinical facts, as we know such facts, with regard to any controversial proposition or one new to me. Inevitably I find myself cutting through the logomachy which so often obscures the real issues. Quite naturally, a delineating process was functioning as I delved into the involved question of psychic determinism. The result is that I find it impossible to discuss determinism as one of the ways of solving universal problems. I can discuss the concept only from a clinical viewpoint, with special reference to what light psychiatry can throw on the idea and, on the other hand, with reference to what help the concept may offer to psychiatric understanding.

* * *

The questions involved in any exhaustive consideration of psychic determinism are closely interwoven with many other issues. There are the questions concerning the essential nature of man, the relationship between mind and body, concepts of the soul and the animating principle, the objective and the subjective aspects of experience, and so on through a long list of opinions and explorations about which men have argued since they first discovered they could "think abstractly." This discovery seems not to have been an unmixed blessing. Reading what philosophers, theologians, and scientists have had to say about some of the key ideas, one is im-

*Presented in abbreviated form before the Guild of Catholic Psychiatrists, Atlantic City, May 12, 1952. Summary published by the Guild, 1953.

pressed by the ability of many to split the semantic hair into an infinite number of threads. Apparent disagreement often seems to come down to a difference in words only, and not a difference in the essence of the concept. The ultimate synthesis may scarcely seem to justify the rather extraordinary circumlocutions which precede it.

One of the first steps in considering this problem was to ascertain what determinism as a concept means to people of diverse viewpoints who have either used it or denied its validity. The best short definition I found of its meaning in philosophy is given by Webster. He defines determinism as: "The doctrine that all acts of the will result from causes that determine them. Determinism characteristically denies the reality of alternative modes of action but may maintain that the will is free in the sense of being uncompelled." Another meaning he gives is: "The doctrine that things as they are are the result of necessity; any theory which regards a certain set of factors or order of phenomena as primary or determining causes of cultural change or social evolution; as, economic determinism."

With regard to the meaning of determinism in and for philosophy, the first sentence seems to follow the general law of cause-effect. Since it is not worded to specify that *every* particular act of the will results from, and *only from*, one cause which invariably produces the particular act, it may be wondered if the present pluralistic approach to questions of etiology in medicine may be applicable, at least in some degree, to an elucidation of psychic determinism. However, since the next sentence quoted from Webster states that determinism denies the reality of alternative modes of action, we seem to be in something of a dilemma in logic. Or is this dilemma just a matter of semantics? (Note the round-about fashion in which determinism "may maintain" the idea of a free will.)

As scientists, we have been trained to associate cause and effect. We have also learned something about sequences of cause and effect, in that a cause for a particular effect may in its turn be an effect of some other cause. It is a personal impression that in present medical thinking we are more concerned with sequences and sequential relationships than we are about precise delimitation of a cause and *an* effect. This is related to our increasing awareness of the many variations, existing not singly but in mul-

tiples, which must be taken into account in explaining the reactions of the human body and the behavior of the individual. Particularly in psychiatry, one-to-one correlations are found practically not to exist with special reference to many cause-effect couplets. Instead, if we attempt to correlate at all, we must deal with multiple variables. Actually, we always find that the simplest act has a complex set of causes. Not only that, but one simple act, a result, will be made up of many interrelated phenomena. And, finally, even our simplest acts cause some sort of effects or results.

The scientific approach is quite different from the philosophical. Science is analytical and descriptive. It starts with careful observations of any sort of phenomena, described objectively and accurately, and proceeds from the general to the particulate. Science uses hypotheses as tools in its search for data which verify knowledge—factual material that can be tested by others who use the same or different techniques. By varying its techniques, science can deal not only with concrete materials, with things and objects, but also with intangibles, imponderables, and the apparently unmeasurable.

Philosophy, on the other hand, deals chiefly with synthesis and interpretation. It proceeds from the particular to the general, largely on the basis of hypotheses. Philosophy requires the data of science, and utilizes them to erect more and more comprehensive hypotheses about problems of the universe concerning which no conclusive data are available. In a sense, therefore, the philosophical approach is speculative and reaches its most interesting peak when ingenious reasoning utilizes known facts to support some huge, over-all synthetic interpretation.

It thus appears that the essential task of science is to seek out facts; to subject ideas, hypotheses, or abstractions to the test of reality; not a metaphysical or conceptual or dialectic reality, but the kind of reality which can be perceived, apperceived, intellectually manipulated, and communicated to others. Here we see clearly the limitations of science and scientific methods, since there remain questions for which science has no techniques of approach, and certainly no answers. Among these questions, some of which theologians and philosophers debate with great vigor, are issues which cannot be brought into sensory representation by any method so far conceived. Notwithstanding what has just been said, there are

matters concerning which we can and do know we are right through the test of repeated experience.

With this short general statement in mind, one may return to the discussion of determinism. In the definition cited, "acts of the will result from causes that determine them," and "alternative modes of action" are denied. This has evidently been interpreted pretty universally as meaning that, deterministically, man has no freedom of action, no volition of his own, but can act only in accordance with specific causes, presumably arising within himself. In psychiatry, if such a doctrine were construed to mean that all behavior resulted from specific intrapsychic cause-effect constellations, there would then seem to be no rationality in man. On abstract grounds, and reasoning from hypothesis to hypothesis according to the rules of logic, it should not be too difficult to arrive at conclusions indicating that man is not a rational being, that he lacks spontaneity, is a robot, and is the hapless victim of his own unfathomable drives. He would then not be responsible for any of his acts, even those that are generally approved. As a matter of fact, most of us have talked just that way, though not in the same language, about some *other* person or persons at one time or another.

It proved difficult to elucidate the place of determinism in psychic functioning. The obstacle is precisely what seems so to delight the abstract thinkers. That is, the philosophers' urge to establish a universal law leads them to erect an elaborate series of hypotheses to a point where the final structure is so tenuous that it can fall simply for lack of support. I am plainly incapable of discussing this, and probably any other philosophical concept, from the universal point of view. Speaking only for myself, most systems of philosophy seem to have their origin in an antagonism to some set of ideas, or perhaps to the promulgator of the ideas. It often seems that more effort is spent in disproving the disliked system than in proving the proposed one, and much of the controversy is distinguished by considerable heat. A tremendous amount of antithetical debate has revolved around religious concepts and creeds, the relationship of man to God, problems of life and death and corporeal and spiritual entities and continuities, so that factors of strength of belief and conviction and zeal, not to mention bigotry, have entered into the discussions.

Determinism as a theological concept seems to have reached its pessimistic peak—so far as any hope is concerned that individual man may have some independence of thought and action and any possibility of creative ability and spontaneity—in John Calvin's stern doctrine of predestination. This inflexible ecclesiastic preached that God foresaw everything and therefore irrevocably sealed the end of very man, whether he was to be saved or damned. Such a pessimistic theology, ground in on the young, who were taught that they were created in sin and born as sinners, certainly gives an ultimate bleakness to life! For, unless the individual finds the courage to become a skeptic with reference to such a doctrine, he must believe that no matter how sincerely he tries to make his peace with God, it will be of no avail in changing the ultimate fate of his soul. Conversely, no matter how great his sins, these too could have no effect on his fate. This is not an attempt to reduce this point of view to an absurdity; it is merely that the absurdity seems to exist in the concept and seems to outweigh any possible human values.

Many philosophical systems are absolutist, all-and-none in their finality and polarity; at the same time they are carried to such extremes that they cease to bear any clear relationship to the facts of life. Many of our philosophers seem not only to reside in ivory towers, but to live in towers on such high peaks that the earth of facts is only distantly glimpsed from time to time. It is here that untrammeled common sense, that rarest of all judgmental factors, can come to our rescue. For common sense makes us put these highly abstract ideas and elaborate systems to some sort of pragmatic test. Sooner or later, this same common sense leads us to relinquish the untrue and the unworkable, the wishful thinking, the superstitions and the preconceived prejudices, in favor of that which is at least nearer the true and the workable, and closer to facts that are testable. Common sense is a matter of "looking at the record"; at its best and in its most refined form, it is science and the scientific method. It requires open-mindedness and a willingness to learn.

Suppose, then, we turn our attention to the object of our professional interests and activities, the individual man. Man is a finite, mortal creature, of complex chemical structure, and he is also a marvelous chemical factory; he has form and structure and movement and function; a reality to himself and to all of us. He is en-

dowed with life operating at several levels—the tropic, the automatic (or vegetative), the reflex, the perceptive, and the adaptive (imagery-thought, selective behavior). Most important of all to us as psychiatrists, man is possessed of consciousness and all that enters into consciousness in the way of memory, ability to reason and form judgment, to learn and to act selectively; the power to feel, to inhibit and to suppress. We might argue till Doomsday about the origin of man and the ultimate causation of his behavior, whether he is mind or matter, or neither or both, and still be at odds about points materialist and idealist; mechanistic or casuistic. There are, however, certain matters of agreement, even though we may not be able to define them in precise and painstaking detail.

At the risk of seeming absurd, let us start on the areas of common agreement with this very elementary proposition: that man is first and foremost a living organism, and as such passes through a life cycle which has its own peculiar laws of growth and development, of evolution and devolution, of sentience, and of death. These laws are similar to, partake of, but are not identical with, those which apply to living organisms generally. In a world of living things characterized by extraordinary variabilities in organisms which possess enough common characteristics to be classed together (the birds or the trees, for example), man's variations in size, shape, color, and general physical structure are remarkably slight by comparison with what they might conceivably be. We are aware of certain evolutionary phases in the development of man, both during the embryological period and in the postnatal organismic behavior. We also see that for many functional capacities, or even for such static matters as size, man is strikingly inadequate when compared with some other animal forms. In hearing, seeing, smelling, strength, speed, endurance, and other specific qualities, man is markedly unequipped by contrast with various particular species.

What distinguishes man from all other living forms is the vast superiority and flexibility of his adaptive faculties. He can think and learn and remember; he can experiment and change his course as a result. He can act and he can learn to modify his actions. His mind—that outstanding functional capacity which differentiates man— gives significance to what he perceives and extracts further meanings by associating and correlating even the seemingly irrelevant. I am unable to find anything in our knowledge

of man or of biology or of the universe in general that says clearly and unmistakably that living organisms *inevitably* follow any precise mathematical or chemical or physical or even spiritual formulae. The first law of life, the living principle, seems to be the law of variation. In the case of the living organism, it is the coalescence of multiple variables into some sort of individuation that gives us the special entity. This is what differentiates the "you" and the "me" and the two billion other people who differ in many ways, from the simple to the complex, but are nevertheless recognizable human beings with a comparatively narrow over-all range of variation.

We clearly recognize the factor of individual differences in people both in structure and in functioning, despite certain common characteristics. We say, and correctly, that every trait or characteristic, every structure and every function, every rhythm and every quality of the human being which we are able in any way to measure or estimate, has its own "normal range of variation." We believe, by extension, that those characteristics and functions which we cannot quantitate must also have some sort of normal or usual range of variation.

We surely can agree—and for our present purposes it is not essential that we be able to explain all these points—that such attributes of the human mind as the emotions and the instinctive drives exist as variable potential capacities. They are part of the teleological endowment of human protoplasm, with its highly elaborated central nervous system. Surely we can be as certain of this as we demonstrably are that intelligence is a variable potential capacity, which can, after a fashion, be measured by utilizing certain tools of comparison. From clinical observations it appears that we also agree on the importance in human development of the experiences, the accidents and incidents, the rewards and punishments, the stimuli and the frustrations, the pressures and the tensions of living. We must include in our considerations the prenatal period of growth in a highly specialized environment, the tremendous event of birth, and then, especially, postnatal experience with all its internal life-process-maturations, its external pressures, and outward behavior and group adaptations. We know that all these things play their role in the development of every one of our potentials, even though we may not be able to assign to each its proper weight. We are always the same, but never the

same; new variables, even if only new combinations of old variables, complicate or alter a habit pattern or introduce a new reaction.

There was a time when the attention of clinicians and scientists alike was focused practically entirely on the conscious mind, and structuralization of mental functions was in terms of "faculty psychology." The divisions of mind thus set up are still useful in studying both normal and abnormal mental functioning. But in the past 50 years we have learned a great deal about the unconscious, a sector of mental functioning that had more or less been accepted as a concept before that time, though very little importance had generally been attached to it. Puzzled to account for many symptoms of disturbed mental function which did not correlate with any organic neurological involvement, the clinician formerly ascribed many of these to "disorders of the will" and tried methods of persuasion and suggestion in their treatment. Hypnosis was more highly regarded for its effect upon the patient's will than for the opportunity it gave to investigate the content of the unconscious in its relation to the symptoms of the patient.

I remember Morton Prince's demonstration of a case of multiple personality, which was later published in detail. It seemed to me then that the great interest was in the phenomenology displayed by the several personalities, with their apparently unlearned and unexperienced characteristics, and with the split in consciousness, more particularly the disordered will. I remember no attempt to correlate the content of the productions with early experience, to interpret the symbolisms, or even to recognize them. Nor do I recall that any special effort was made to analyze the rather marked emotional reactions of the patient. It seemed to me then, and even more strongly now, that the unconscious as a repository of dynamic forces, submerged memories and emotional conflicts simply was not recognized. It certainly was not probed and utilized in the interests of the patient. I say all this despite the fact that my own notions of the unconscious at that time were extremely nebulous, because, as short a time ago as 30 years, the will and its disorders occupied so much time and attention in psychiatric training.

The development of psychoanalytic facts and theories regarding the unconscious and its role in the production of mental disorders, as well as in everyday life, has revived the controversy about psychic determinism and its ultimate relationship to individual re-

sponsibility. I gather from reading and discussion that one argument runs like this. The unconscious is both a vaster area and is far more dynamic or forceful than is the conscious. As a result, our behavior, our emotions and even our thinking are largely dictated by forces entirely outside of conscious control. It should be recalled here that the unconscious contains not only the biological instinctive drives and impulses, the egocentripetal, asocial, amoral, hedonistic motivations, but also the repressed material related to painful, emotionally traumatic experience, plus the unassimilable emotions such as guilt, related to unsolvable (at least unsolved) conflicts between opposed inner drives. This is not, of course, a complete description of the unconscious, its content and its dynamics. For present purposes it is only necessary to point out that for the unconscious to operate effectively, it must have some relationship to consciousness. In some operations, it must work through consciousness; in others, we become acutely, and often painfully, aware of the results of unconsciously determined activities.

The id, the ego, and the super-ego are constellations of dynamisms represented in both the conscious and the unconscious. There is a barrier to free passage back and forth, else there would be chaos indeed, but the barrier is not impermeable. It appears that certain emotions have in fact a considerable facility in passing from the unconscious to the conscious where, being detached from the original nucleus and thus free-floating, they attach themselves to other nuclei and play havoc with what might otherwise be suitable, adequate reactions.

What I have said about the conscious and the unconscious seems to me merely to multiply the number of variables which must be brought into some sort of co-ordination before any kind of activity representing expression can ensue. One could increase the number of variables rather considerably if the automatic and reflex patterns that might conceivably be involved were also considered.

Probably the point can be made clear by concentrating on what happens in the selection of a course of action, the variables lying in both the conscious and the unconscious. I speak here of "selection of a course of action" quite deliberately, since I believe that this can and does occur. Even in the case of well-established habit patterns, whether simple or complex, there was a time in development when these had to be learned by patient repetition of,

not only the positive action, but repetition of the inhibition of the opposite action as well. Just as a movement of an arm in one direction demands contraction of one group of muscles and relaxation of the antagonists, so it seems to be with mental processes. One can see in the negativism of children, how a stimulus such as a request, an order, or an offer starts up contradictory impulses, and how the opposing impulses may come to expression through different parts of the motor system. Thus a child may say, "No I won't," as he actually begins to carry out the requested act.

Any stimulus, simple or complex, of necessity evokes a number of associations, for recognition, for understanding, for judging, and for expression. It is axiomatic in our profession that a repeated constellation of historical, physiological, psychological, and social circumstances which seem to be roughly parallel or comparable by our best standards of judgment, will certainly not always evoke an identical response, either in the same or in different individuals. Something was added or subtracted, perhaps a chance factor; something was learned, or emotional values varied. What simply must be true, at least to my way of thinking, is that the organism is in a state of constant flux, and so is the mind. Changes in reaction are, therefore, to be expected as a matter of choice, not of compulsion.

Philosophers may not accept this because they become absorbed in their own doubts and theories. They do not seem to follow the method of seeking facts with which to answer current questions, well knowing that each new set of answers has its own crop of further questions. This method is the crux of the scientific approach. As clinicians, we know that eventually we arrive at a point where we can find no further answers. In psychiatry, for example, our great question is: Why? What makes people behave as they do? Why does one child with an IQ of 150 do poorly in school, so poorly in fact that neither his teachers nor his parents can accept the fact of his intellectual superiority, while another child of the same age and IQ does even better than his superiority would indicate? Except conjecturally, based upon prior clinical experience, no one can possibly answer that question as it stands, but we do know where and how to look for the correct answers. Then, at some place along the line, we arrive at a point where we can no longer really know what the concatenation of circumstances and causative factors actually was. We can only make some inferences whose probable

validity will depend on the breadth and depth of our clinical experience and how well we have assimilated it. We could theorize about the difference in behavior of the two hypothetical children and erect a system of cause-effect relationships and sequences. The systematic answer could be completely true to life and yet not apply in more than small details to any particular child.

It seems to me that a philosopher could, if he wished, take the proposition as stated and proceed from hypothesis to hypothesis until he arrived at some complicated and abstruse set of conclusions, which he would present as his final judgment of the reasons for the difference. When one reads that a philosopher (Zeno) reduced reason to an absurdity, so that even its existence could be denied, it can be concluded that philosophers can prove or disprove anything. We all know that statistics do not lie, but that meretricious, or even honest, statisticians can certainly make statistics prove, or seem to prove, almost anything. We also know that there is such variability in human affairs that statistical probabilities and the law of averages cannot be universally and dogmatically applied to the single unit, but only to a mass of units.

When a philosopher can prove that a man pursuing a moving tortoise can never catch up with it and that a moving arrow does not move (Zeno did both), and another philosopher says that "one might also prove the contrary" (that the arrow moves) but that "it would be more difficult," then my poor wits really get befuddled! Such abstract conclusions are contrary to what I actually experience in perceptive reality. I see that the arrow actually started from one spot and reached another, and that the man did catch up with the tortoise and even passed it. Practically, it does not seem to matter whether it is claimed that things or individuals have no existence outside the mind, or whether mind itself exists, or what reason and intelligence are, if we are thinking in a cosmic sense. One thing I cannot conceive, and, therefore, cannot accept, is the validity of any such concept as there being *only* matter or *only* mind, or any other absolutist unipolar either-or view. I crave a synthesis, a reconciliation of opposites which can be rationally apprehended and maintained as having some definite relationship to experience—not just to "my" experience or to "yours," but to comprehensible universal experiences. We all know, I am sure, that we do not need to live every possible experience to be able to understand it in some degree, to accept the fact that it actually

happened to someone, somewhere, some time, and to be sorry for, or rejoice with, the one to whom it happened.

The synthesis that is of interest may be weighted in any direction. It may be primarily based on ethics, morals, health, science, logic, natural or supernatural phenomena; or on idealism, realism, dualism, materialism, psychophysical parallelism, or on any of a long list of ideas which men have ardently espoused and erected into systems. But the synthesis must include more than any one primary idea that is blown up to the point of being regarded as the ultimate or only solution or explanation of the universe, or the sole set of laws that govern phenomena and their interrelationships.

The one concept that is clear to me about life is that it is composite, complex, and variable. I cannot conceive a single, ultimate, cosmic, universal law. I can conceive of a system of laws that has some sort of common thread, which, nevertheless, permits the permutations and commutations that we see all about us, plus the many that we know or can prove by inference and by some sort of supportive evidence which is understandable. The kind of laws I have in mind even leave us the freedom to believe that there are things not yet discovered or even dreamed of, and that laws exist which we do not yet know. My concept is of a live, growing universe, especially perhaps, of knowledge and thought, and including the belief that man grows mentally, too, in irregular spurts. I can understand that matter exists in both static and dynamic forms. I can accept the evidence that inorganic substances undergo transmutation, though whether the process is spontaneous or must be developed and controlled by external agencies is not entirely clear. What substance and form and life mean to me does not necessarily indicate what they mean to any one else. We may agree, and the more we agree the more certain is the similarity of our mental processes, and of the shape, size, color, consistency, function, etc., of the observable materials. Because humans have imagination, they can create mental and verbal images of what are insubstantialities, at least so far as any direct sensory experience is concerned, and these may powerfully influence thought, emotion, and action. This is a fact to me because it is something I have observed in myself and in others. Even in philosophers.

To find good examples to prove the coexistence of determinism and freedom of choice, a synthesis of concepts in which I firmly

believe, has not been easy. I devoted a lot of thought to the matter, practically always on rather complicated problems, because I was also thinking of the interrelationship of responsibility. Then a very homely event provided a simple example which illustrates rather perfectly my conception of the relationship between determinism and free choice.

I developed a positive desire for an apple, just why I do not know. I am sure that there were many physiological stimuli arising in several areas. I will leave it to your imagination to enumerate the various sensory and motor nerve impulses that were involved in setting up a feeling of need for a particular something to ingest. I will also leave to your conjecture which and how many psychological associations and processes may have been set to work to eventuate in the ultimate mental representation or conclusion that I wanted an apple. This total process in which potentially thousands of minute bits were associating and reassociating must be a deterministic operation. In other words, arriving at that sort of conclusion is a simple and direct example of determinism. In the next act, that of selection, I see nothing deterministic. I went to the refrigerator and found three apples, none of which coincided with the apple I had mentally conjured up. However, each apple had certain different desirable characteristics. I had therefore to make a choice, which I did, not blindly but deliberately. Granted, had I been sure that apples were available, this might have been the fringe-of-consciousness initial stimulus which eventually forced the realization that I wanted an apple, yet the process by which the conclusion was reached is still determinism. The fact that there were apples was, as far as I am aware, fortuitous, but the choice was mine and a free one when I found them.

Then consider this. I like cheese with apples, and I spied two of my favorite kinds which I definitely had not known were available. I became aware then that I had another decision to make. Either I would not take any cheese, or I would take one or the other (and if so, which one?), or I could have some of each. There was still another decision to be made. Should I omit the apple and eat only cheese! The possibilities were quickly weighed, a conclusion reached and the act completed with an untrammeled feeling that I had made a free choice. (If you want to know what I did, I ate the chosen apple without cheese and with considerable satisfaction.)

Suppose, however, there had been no apples in the bin. Then three courses of action would have been open to me. I could have picked a substitute; I could have felt more or less frustrated and gone without any food; or, if the desire (drive, will) were strong enough, I could have gone in search of a fruit stand to buy an apple. But here again it would have been my own free choice among the alternatives. To sum up, the fact that there were alternatives seems to be an example of determinism, but the choice of the alternative is, in my judgment, a matter of free will. This may not be superior logic, but it fits the facts as I see them.

This admittedly naïve example led me directly to another combination of circumstances of definite psychiatric significance, about which I believe all of us as psychiatrists are in agreement. Every individual can react only within the limits of his biological capacities, as modified by development, frustrations, compensations, disease and accident. His reactive capacities are therefore determined for him. The factor of chance, over which the individual has no control, merely helps to complete the picture of determinism. But within the framework of the limits set by determinism, every individual has a wide range of freedom of choice, simply because there are always variations and, therefore, alternatives. Even in those things which are most rigidly fixed in terms of structure, there are still alternatives when it comes to the resultant action. We can walk backward as well as forward, or we can stand still. Most important, we can always find reasons for what we do or do not do. That our stated reasons may merely be camouflage for motivations which we wish to conceal seems to be further proof that we can and do make choices, which are free, between multiple alternatives with which we have at some time or other experimented. There is the additional fact that we can and do experience sharp pangs of indecision because of strong conflicting impulses to act, and that we may carry through a course of action even despite marked psychic pain or sorrow about the course we decide we *must* pursue.

We should at least glance at the concept of will as the final step in this attempt to demonstrate the actual compatibility of psychic determinism and freedom of choice. People are inclined to discuss the will and the idea of free will as a fixed, unitary concept, but it seems possible to demonstrate that this unity is far from being the case. Quite different meanings are attached to the word "will"

according to whether it is being used in ordinary conversation, is being applied in psychology and physiology, or is being debated by philosophers.

If bluntness can be pardoned about this particular issue, I would record my deliberate opinion that at least some philosophers have made a mare's-nest out of a matter which seems comparatively easy to resolve. This may seem a naïve statement, but I would support it by citing William James, who chose "the alternative of freedom" for "ethical rather than psychological reasons," having stated flatly that the "question of free-will is insoluble on strictly psychological grounds." James points out that determinism is only "a clear and seductive conception" which one *must* espouse if he accepts the "great scientific postulate that the world must be one unbroken fact, and that prediction of all things without exception must be ideally, even if not actually, possible." A moral postulate which he outlines would lead one to espouse the contrary view. He concludes that "when scientific and moral postulates war thus on each other," and there is no objective proof, then the "only course is voluntary choice, for scepticism itself, if systematic, is also voluntary choice."

This passage bothered me, since James was both a competent physiologist and an extraordinary psychologist. But the thought occurred that he was being theoretical rather than scientific, and perhaps even a bit of a mystic. What it seems that James overlooked here (and I may have missed something myself) is the simple factor of individual, human psychology.

One wonders how far we do actually order our lives on postulates, or on ideals alone. Can the world—the great cosmos, the ultimately unknowable, at least illimitable—actually be one "great unbroken fact"? What sector of the universe do we, any of us, worry about? I doubt that any of us feel, or think, or judge, that we have had *no* opportunity to choose a course of action. We have all been confronted with alternatives, and we have all had to make choices, sometimes painful, sometimes pleasant. Granted that the choice was determined by the total configuration of our personalities at that point, and that we could not have made a different decision *as we saw the matter at the time,* do we honestly feel that we could not possibly have made any other decision? I believe that our insight, our auto-criticism, tells us that we have not only frequently done the inevitable in terms of accumulated pressures,

but that we have also frequently done some sidestepping. Are we to accept plaudits for our good decisions and blame fate or the devil for our bad ones? Are we any more or less responsible for the one than for the other? We can only decide and choose and act in accord with what we are at a given time. What we are is determined by all of our past experiences, our stage of development, and our potentials. Man in the mass may follow deterministic paths, but man the individual is different.

Because we are living creatures, with complex minds full of desires and purposes, aims and objectives, frustrations and compensations, we find all manner of means in which such a dynamism as desire (one of the definitions of will) operates in the selection and formulation of our perceptions, ideas, memories and, eventually, actions. We analyze, that is, proceed from a whole to its parts, or, in another idiom, we disassociate ideas aroused by perception; we associate them with other wholes or parts according to our purposes; we recombine parts into new wholes; or we reassociate through reasoning in which we weigh alternatives, use our imaginations, and devise methods for satisfying our inner drives. Our ultimate purposes seem to be subject largely to determinism, but how our deterministic synthesis finally becomes effective is a matter of selection for which we are the responsible agents. Since no psychic experience is ever completely lost, even though repressed into the unconscious, and mental life is continuous (the great discovery of this century), it seems inevitable that there must be determinism and also choice. There are entirely too many mental variables, too much content both conscious and unconscious, for any other conclusion to be tenable, at least to me. That freedom of choice is hampered or deflected by complexes and conflicts, by neurotic compulsions or psychotic reasoning, is perfectly true. This is only another example of the fact that our freedom of choice operates only within the framework of our total personality potential. It does not change the factor of multiple choice; it merely emphasizes some of the limitations imposed upon our ability to exercise the freedom constructively.

If then, psychic determinism and freedom of choice are not incompatible, but do actually operate in conjunction, what about responsibility? The only way I can approach this is by considering two widely separated aspects of responsibility. The first is the legal concept, as exemplified in the criminal law with reference to

mental irresponsibility as a defense against a criminal charge. The other aspect is that of the individual's own feelings of responsibility, and in this connection I shall use guilt as an example and discuss it very briefly. Responsibility is a word used in many connections, but the two senses chosen here seem to offer the best possibilities for expounding the special relationship now under discussion.

The legal concept of responsibility for criminal actions is really much more confused than seems to be generally realized. The law makes a great point of willful acts which are contrary to the legal code. But under certain circumstances, as with the feebleminded and children under 15 or 16, according to state laws, an Aristotelian concept appears to operate; that is, the will does not function in accordance with what reason holds to be good or bad. In other words, these groups plus the intoxicated and the insane "do not know the difference between right and wrong" and, by extension, the implication is that the will is disordered. Or, in terms of the concepts I am advocating, freedom to choose the right (in this case the legal) course of action is impaired to such an extent that the individual is not responsible before the law. This sounds as absolutist as many philosophical systems, yet look at the exceptions and watering-down shown in the grades of homicide, of larceny, assault, robbery and other crimes, and the variations in punishment. Or, on the psychiatric side, observe the legal acceptance, at least at times, of the idea of "the irresistible impulse," the type of obsessive-compulsive neurotic activity with which the psychiatrist also deals in non-criminal cases.

I believe two factors strongly influence the legal attitude. One is called "extenuating circumstances"—a recognition of the fact that external provocation can reach a point where any ordinary individual will react with hostility and aggressive acts. Psychiatrists would grade such circumstances by knowledge of the individual's personality; but the law operates in terms of some hypothetical averages as to people's limits of endurance. The second factor, an individual psychological one, involves the defendant's concepts of right and wrong, as shown by the sort of self-justification advanced for the acts, plus absence or evidence of guilt feelings about the acts. Judges have great difficulty in understanding the psychodynamics of the psychopath, or accepting the psychiatrist's often rather labored attempts to explain them. The courts

also have their own standards for diagnosing "insanity." I have been told by judges, even recently, that they hear psychiatric testimony only because it is the law, but do not allow the testimony to influence their own decisions.

Delinquent and criminal behavior may be the norm of behavior for people who have been reared in certain ways. Much anti-social behavior is based upon major or minor mental disturbances, but some of it is due to archaic or anachronistic laws. Samuel Johnson is quoted as saying, "The law is the last result of human wisdom, acting upon human experience for the benefit of the public." This would both make the law a great abstraction and remove it a long way from the individual, as though he were an unimportant unit of "the public." I found this sentence in a recent law publication: "To continue to follow a right and wrong test enunciated in 1843 [the M'Naghten case] despite the growth of psychiatry would mean that the Common Law is unable to adjust its rules to medical knowledge." This, of course, refers primarily to legal insanity as a defense against crime. If we, as psychiatrists, regard recidivists as being in greater or lesser degree mentally sick, even though not insane or feebleminded, then we must stand for a concept of limited or qualified responsibility, and believe that the framework of determinism is pathologically altered so that freedom of choice is impaired. There is one final point to be remembered here. What constitutes legal offenses against society, and what represents adequate punishment therefor, vary within wide limits from time to time in the same community, and at the same time in different communities. Even though these variations may be slow in evolution, they do affect both individual and legal ideas of responsibility.

With regard to personal guilt feelings, it is the capacity of a person to experience guilt feelings that helps so much to convince me that psychic determinism and freedom of choice must co-exist; because guilt, the impact of the super-ego or conscience on the choice of actions, keeps the individual from merely reacting reflexly and hedonistically to stimuli. Guilt is involved in the sense of responsibility, not only for the person's own actions, but for others and for his relationships with them. The over-all picture is that of the super-ego battling with the egocentric id impulses. The super-ego and the guilt feelings may be pathological in strength and impair the freedom of choice, a familiar psychiatric

picture, but that is not the point just now. Without a normal quantum of guilt feelings, I cannot see how we could develop a balancing humility, a sense of responsibility for our own actions, a constructive feeling that we *do* have freedom of choice, and the driving force to strive to reach our ideals. That the super-ego and guilt feelings are first elaborated for us and stimulated from without is beside the point here. It is their incorporation and elaboration within our own conscious and unconscious that makes them so very important. To think through what such a synthesis can mean to each of us, we must inevitably include its meaning not only in secular matters and in our clinical work, but also in terms of our fundamental beliefs.

If I have managed to present a reasonably clear account of what I understand and think as a clinician about determinism and responsibility, then I have indeed achieved a considerable measure of satisfaction.

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Ford, John C.: Depth Psychology, Morality, and Alcoholism. In this excellent monograph, published by Weston College (1951), Father Ford presents an extensive review of the literature on depth psychology, with particular reference to its relationship to Catholic doctrines of faith and morals. His most important conclusion is to the effect that the moralist welcomes any light that depth psychology can shed on the effects of unconscious influences upon free or conscious decisions. This writer found his discussion a very illuminating critique of the several concepts of the unconscious and its relationships to the conscious. It helped greatly in the final synthesis of the positive compatibility between determinism and free choice. Father Ford emphasizes in several ways the fact that moral responsibility in the mentally disordered is to be considered in a quite different light than in normal people. I have gained the impression that Father Ford, in common with clerics of other faiths with whom I have talked, or whose writings I have perused, recognizes that morbid doubts, compulsions, anxiety and guilt feelings not only exist, but that they impair freedom of choice and action. By "morbid," I mean uncontrollable thoughts and feelings and impulses to action that dominate attitudes, and pre-empt the field of consciousness to a degree which interferes with or abolishes those rational processes which are necessary to achieve a balanced

relationship with reality. A simple example would be that of persons with such a morbid fear of crowds and enclosed places (pantophobia and claustrophobia), and such people certainly do exist, that they could not even go to church. Yet a church and religious services should, according to all our ordinary ideas, be safe and comforting. Father Ford seems to see what is perfectly clear to the writer as a psychiatrist, i. e., that a mental disorder, whether it amounts to "insanity" or not, impairs freedom of choice, and therefore responsibility. I cannot be sure that Father Ford would agree with me that this impairment of freedom of choice is primarily related to an underlying pathological deviation in the complex of factors which make up the mental set; that is, that delimit and circumscribe the elements in psychic determinism of the particular individual at some special time. But it seems clear to me that Father Ford's general point of view is that freedom of choice, in whatever field it may be exercised, can only be operative within the limits of the individual's character and personality structure, however these may be determined and whatever pathology may modify them. I am also sure that Father Ford's point of view often differs from my own with respect to details, but I believe his general point of view is similar to my own.

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The citation from Samuel Johnson and the comment on Common Law and medical knowledge are from a bibliography of recent publications on "Insanity as a Defense to Crime," published in the March 1952 issue of *The Record of the Association of the Bar of the City of New York*.

A number of other works on philosophy and pastoral theology were consulted, but the foregoing represent references which seem the most pertinent to my thesis.

THE CONCEPT OF THE UNCONSCIOUS*

BY LUDWIG EIDELBERG, M. D.

The concept of the unconscious was introduced by Freud on the basis of the experiences he had gained while trying to develop a psychological method for the treatment of neurotics. Most of his contemporaries rejected his suggestion with scorn. Some of them tried to discredit the scientific character of his undertaking by pointing out that, as psychology had not been used before to deal with the problems of the unconscious, physiological methods should be employed for its study.

The importance of Freud's achievement is obviously not due to his decision to use the word "unconscious" but to his *discovery* of a psychological method which made the study of the unconscious possible.

Psychoanalysis, like other sciences, did not start its work with exact formulations of the technical terms it intended to use. Instead, on the basis of clinical experiences, certain ideas were described under names of which the meanings were kept vague purposely to avoid unnecessary rigidity.

Psychoanalytic terminology is, therefore, rightly compared to a filing system in which, not the title of the file, but its content, deserves attention.

Keeping this in mind, only a superficial and brief description of the terms used herein will be attempted by this writer. He cannot present a complete survey of all analytical terms and what they mean to different analysts, but he wants at least to indicate how he proposes to use them in this study.

According to Freud:** "There is no need to characterize what we call conscious: it is the same as the consciousness of philosophers and of everyday opinion. Everything else that is mental is in our view of the unconscious." Having considered previously that "mental,*** from an anatomic point of view is localized in the central nervous system, Freud then divides the territory of the unconscious as just defined into two parts: the preconscious and the un-

*This paper will appear as a chapter in Dr. Eidelberg's forthcoming book, *An Outline of a Comparative Pathology of the Neuroses.*

**Int. J. Psychoan., 21:40.

***Int. J. Psychoan., 21:28.

conscious proper (able to become conscious and unable to become conscious).

The term "preconscious" describes all the material which, while unconscious at a certain moment, may easily become conscious as a result of the decision of the total personality to make it conscious. The term "unconscious," on the other hand is reserved for phenomena which under ordinary circumstances are unable to enter into the conscious part of the personality. The presence of these phenomena can only be inferred; and they can become conscious only after *resistance* has been eliminated.

While, from a theoretical point of view, it may be impossible to prove that all sensations originating in the central nervous system can become conscious, we know that some of them do, and that consciousness depends on many factors and varies with different individuals. Without setting limits to what can be examined by a psychological method, the analyst seeks to concentrate his work on the ordinarily inaccessible part of the unconscious, which can finally become conscious (after resistance has been overcome).

While Freud originally expressed the idea that whatever had become conscious and had been repressed could be recovered, he admitted in later years that some of the repressed material may be lost forever. The unconscious phenomena the analyst is interested in, are obviously the ones that are responsible for the presence of the defense mechanisms and that cannot merely be guessed or assumed but can also be demonstrated and eliminated.

The discovery of a method capable of giving entry to the hitherto unknown part of the human mind did not induce Freud to neglect the importance of consciousness: "But none of this implies that the quality of consciousness has lost its importance for us. It remains the one light which illuminates our past and leads us through the darkness of mental life."*

Most of the critics of Freud's concepts of the unconscious failed to realize that his insistance on using a psychological method was based on the ability of this new method to translate unconscious material into conscious.

In his study of neurotics, Freud gained the impression that their symptoms were connected with such psychological phenomena as ideas and emotions of which they were not aware. While other doctors have accused neurotics of lying in order to fool the exter-

*Int. J. Psychoan., 21:84.

nal world, Freud discovered that they are actually fooling themselves. They are hiding, behind their symptoms, their "real" desires, but they are not aware of the game they are playing and do not have the power to uncover and to face the truth.

In addition to a deliberate lie created to protect one individual from another, an internal "lie" is thus discovered; it protects one part of the individual from another part. In this internal lie, the conscious part of the personality is separated from the unconscious. As a result, the satisfaction of drives that are present in the unconscious is interfered with because satisfaction can only take place through the actions of the conscious part of the personality. This separation of the unconscious from the conscious was at first regarded as responsible for an increase of tension in the unconscious. Later, however Freud recognized that a certain amount of instinctual discharge can be achieved in spite of the fact that the conscious part of the personality is separated from the unconscious part. It is now easy to see how this discovery led to the structural concept of psychic organization, a topic which will be taken up presently.

Continuing the discussion of the unconscious, it should be pointed out that the material of interest here, while no doubt also approachable by physiological methods, can be verbalized as: desires, needs, fears, tensions, etc., which, while unknown to the patient when he starts his treatment, do become conscious with the help of the psychoanalytic method.

The material gained in analysis consists of certain motoric actions which can be seen by the analyst or described by the patient, certain ideas which the patient can express and the analyst understand, and certain emotions which may be partly described by the patient and partly guessed by the analyst. By identification with the patient, the analyst is also able to experience certain emotions; but he must be careful not to project his own emotions into the patient and he must be aware of the fact that the presence of an emotion in himself is not a proof that a similar emotion, or any emotion at all, is present in the patient.

The idea that words and gestures can be used, not only to express our ideas and feelings, but also to hide them, did not originate with Freud. The concept of the ostrich burying its head in the sand has been familiar to mankind for centuries. But Freud was the first to develop a scientific method to prove that a neurotic

was not even master in his own home, that there was a part of him which he was not aware of, and that this part was able to fool him.

Independent of philosophical reservation, the word "unconscious" as it is used in analysis can be understood properly only in connection with concrete-clinical examples. If we talk about an unconscious wish we are aware of the fact that some part of this wish sooner or later will become conscious or become approachable by a psychological method. Therefore some authors, when they are referring to the unconscious, use the term "partly unconscious," in order to point out that the phenomena psychoanalysis is interested in can become conscious under certain conditions. (The term "partly unconscious" should not be confused with "preconscious" which can always become conscious.) Some patients, when told about unconscious wishes they are supposed to have, have the impression that these wishes will never become conscious and that they are not responsible for their presence. The words "not responsible" mean that such wishes are something they will never be able to influence; and such patients accept an analytical interpretation as if it referred to the number of red blood cells they have. But what is suggested in analysis as being unconscious is something which although not "visible" to the patient at a given time may become visible later.

In psychoanalysis today, much more is known about pathological than about normal psychology. In other words, analysis is chiefly concerned with phenomena which "don't make sense," or phenomena which do seem to make sense to the patient but not to the analyst who, on the basis of the experience gained in other cases, expects to find the real explanations for such things in the unconscious.

One typical reaction of a patient to a suggestion that something is unconscious is to accept it at once and to use it in order to avoid responsibility for his problems. If it is true—he argues—that this symptom was created by a part of him he is not aware of, obviously he cannot be expected to do anything about it. In taking this attitude he seems to support the critics of psychoanalysis who condemn it because it gives the patient permission to "enjoy" his illness, free of feelings of guilt.

This is an error! The patient (not the critic) will discover in his analysis that the analytic treatment, while freeing him from suspicions of having consciously created his symptoms to avoid

his social responsibilities, is aimed toward having him conquer the neurotic products of his unconscious. Without blaming the patient for his errors of the past, the analyst will try to show him that it is up to him to utilize his new insight, not only to explain what has happened in the past, but also to prevent it from happening again in the future.

The following example may be used as an illustration of what has just been said: For one of the writer's patients,* psychoanalysis meant freedom to say whatever happened to pass through his mind and he thought that, by exercizing this freedom, he would finally be cured. To eliminate his resistance, the writer had, at first to make him recognize that his endless talk did not represent acceptance of the basic analytical rule. For a long time he refused to face what he was saying because he was afraid that, after understanding it, he would have to remain silent. The writer had to prove to him that he enjoyed talking and that he was afraid to admit it. His talking meant not only: "I love, hate, suck and swallow my mother," but also, "It is not true that I have such desires, the truth is that I am interested in being cured by analysis." In that way, his uninterrupted talk served the satisfaction and the rejection of sexual and aggressive impulses. The unconscious responsible for the defense mechanisms is neither a philosophical concept nor an anatomical organ over which we have no control, but a part of us which has lost its conscious quality. This conscious quality can be regained with the help of analysis.

The analyst tries to show the patient that instead of accepting punishments connected with the toleration of neurotic symptoms, he may destroy the symptoms by finding their unconscious meanings.

The analytical aim is to help the patient substitute a conscious solution for an unconscious one. Without trying to interfere with the patient's habits, character and philosophy, the analyst wants him to face the truth, the internal as well as the external one, and to make his decisions on the basis of what he knows, so he can obtain what he wants.

Just as a district attorney would not throw away a code letter found in the possession of a suspect merely because it did not contain a frank confession of crime in plain English, the analyst

*Eidelberg, L.: A contribution to the study of resistance. PSYCHIAT. QUART., 26:177.

should not expect to receive unconscious material undisguised. Instead he will have to collect whatever he gets hold of, in order to establish a chain of circumstantial evidence leading to the neurotic symptom. The patient, in this simile, is not only the suspect, but he also plays the role of the jury and helps the "prosecuting" analyst to prepare his case. It is not surprising, therefore, that analysis can only be successful if the patient is interested in having his unconscious exposed and that analysis fails whenever his co-operation is refused. However, while the lawbreaking culprit whose responsibility has been proved in court must go to jail, the patient who recognizes his responsibility for his illness becomes free to leave his neurotic confinement.

The chief difference between a neurotic symptom and a normal act is the fact that in any so-called normal act, the individual is aware of what he wants; he remembers experiences he has had in connection with past attempts to satisfy such a want; he recognizes the limitations of internal and external reality; and, finally, after having reached a decision, he either proceeds to satisfy his wish or he modifies, or rejects it. In the neurotic symptom on the contrary the wish itself either does not appear at all before the conscious part of the personality; or, if it appears, memories of past experiences connected with it are blurred or not available, or the superego appears to be too severe or too lenient; and, finally, the external world is not seen as it is but as the patient would like it to be (unconsciously). The facts that the patient keeps from his conscious mind, and his ability to deal with certain wishes without becoming conscious of them, are responsible for the neurotic solutions he reaches.

As has already been said, the discovery of the psychoanalytic method has taught us how to bring, into the open, ideas and feelings the patient is not aware of. The patient's ignorance is not caused by lack of intelligence or bad memory. The material responsible for his symptom is unknown to him because he has pushed it into his unconscious and has insisted on keeping it there. The neurotic symptom is the result of a fight between a wish that is trying to become conscious and the patient's refusal to face it.

The division of personality into a conscious and an unconscious part represents the systematic approach, whereas the description of the neurotic symptom as resulting from a conflict between these two parts of the personality is referred to as a dynamic approach.

After Freud had recognized that a defense against the derivatives of the unconscious could not be described as conscious, he introduced the topographical or structural approach. In addition to the division of the mental apparatus into the systems of conscious and unconscious, Freud divided the total personality into three parts. The boundaries of the three parts, the id, the ego and the super-ego cut partly across the old lines separating the systems of the conscious and the unconscious. The id is described as totally unconscious, whereas the ego and the super-ego are partly conscious and partly unconscious.

This new division of personality permits description, not only of demands from the id, but also of defense against them by the ego, as unconscious.

While the former differentiation by systems does not lose its heuristic value, the newer concept allows a better understanding of the subject of this research because it allows description, not only of the repressed, but also of the repressing factors, as unconscious.

The id contains the instincts which represent the *vis à tergo* responsible for all our activities. It can only be examined through study of the so-called derivatives of instincts which are formed after instinct tension has passed the ego-threshold. The id has no connection with the external world and opens toward the ego. The id is interested only in the discharge of instinctual tension but is unable to provide this discharge. Its activity is governed by the so-called primary process. The differentiation between good and bad, between yes and no, the recognition of time and space, are not present in the id.

Under the influence of the external world, part of the archaic id became the ego which controls motility, examines the external world and represents a link between id and super-ego. The ego may try to eliminate the unpleasure of increased tension by a wish to discharge it. As wishing alone is unable to provide such a discharge, the ego discovers that an external object and a motoric action are necessary if instinctual unpleasure is to be eliminated. The ego may also decide not to eliminate the instinctual urge but to endure the unpleasure. The super-ego represents the moral part of the personality. It is the result of identification with the parents or their super-ego. As a result, it observes, gives orders,

sets up prohibitions, and praises the ego.* While the super-ego of a child, the so-called infantile super-ego, represents a foreign body, containing the admonitions and prohibitions experienced by the child, the super-ego of a normal adult is completely assimilated. The individual has selected, among the orders he has received, only the ones he considers justified and has blended them in such a way that they represent part of his own personality.

A survey of the psychoanalytic literature (including the papers of this writer) shows that the term "ego" is used not only to describe one part of the personality but also is employed where acts of the total personality may be involved. For instance a symptom is described as containing elements of id, ego and super-ego; and the reaction of the patient to his symptoms is referred to as ego-alien, although—to be exact—it may be alien, not only to the ego of the patient, but to his total personality.

Students of the psychology of the normal individual may consider this division of the total personality to be an unnecessary complication of their work, and may complain about the difficulties connected with the separation of the three parts of the personality from each other; in pathology, however, the topographic (or structural) approach has proved its value.

Using a topographic presentation of the act of eating by a normal individual as an illustration, one may say:

As a result of the accumulation of certain metabolites and the loss of others, an instinctual tension is mobilized in the id, is recognized by the ego and is experienced by the total personality as a feeling of hunger. The experience of hunger may take place in the total personality which, through its ego, remembers having experienced similar feelings before, and remembers having discovered external objects and proper methods to eliminate this hunger. "I feel hungry," changes into "I want to eat." Again with the help of the ego, a plan to find food, to incorporate it, is made and presented to the super-ego. If approved, this plan may be executed, the food incorporated and the hunger satisfied. In cases where no food is available or where the time and energy required for eating are needed for other purposes, the total personality may postpone the satisfaction of hunger. As a result of such a decision, the wish to eat may be suppressed (not repressed). The knowledge that one is hungry and desires to eat may disappear for a certain

*Freud, S.: Int. J. Psychoan., 21:75.

time. Something similar may take place if the super-ego rejects the wish to eat. The suppressed wish will become preconscious and regain its conscious quality whenever the total personality decides to allow it. However, the hunger may last too long for the total personality to suppress it.

This is a schematic presentation of how the three parts of the personality function (in case of hunger) under normal conditions.

Under pathological conditions, however, a wish representing instinctual tension cannot became conscious because the ego blocks its entrance into consciousness. As a result of this blockade, however, the part of the ego used for the blocking purpose becomes unconscious. Presently instead of the repressed wish from the id and the repressing ego entering the conscious mind, something which contains elements of both will enter.

According to the unpleasure-pleasure principle or its modification, the reality principle, the individual tries to overcome unpleasure and obtain pleasure—any pleasure at once, or a better, safer pleasure later than can be obtained at once. However, he is often unable to achieve this goal. The object he is looking for may not be available or the enemy is stronger than he anticipated and defeats him. He fails at arriving at a harmonic compromise of his various desires, they contradict each other or his super-ego produces feelings of guilt. Consequently, instead of achieving pleasure, he suffers unpleasure. He may now avoid this unpleasure by repressing the knowledge of it. In that way two forms of repression may be differentiated: (1) repression by the ego, trying to ward off the derivatives from the id or super-ego; (2) repression by the total personality, trying to eliminate the consciousness of the "foreign body" representing the repressed and the repressing factors.

In addition to the mechanism of suppression which allows the total personality to avoid, for the time being, the feeling of unpleasure, the mechanism of repression seems to protect the personality from the experience of unpleasure for an indefinite time. However, this mechanism of repression may be activated *only* under special "traumatic" conditions.

If the individual were omnipotent he would have the power to stop any unpleasure immediately after he experienced it. But as he is not omnipotent the fact that he often suffers unpleasure is not a contradiction of the pleasure principle.

Obviously there are two ways to remove unpleasure: (1) to obtain the external object necessary for instinctual satisfaction; (2) to eliminate the knowledge of unpleasure. The latter possibility will be discussed here.

While it is generally accepted that the ego is able to control the id by mobilizing a so-called opposite instinct fusion or by turning the instinct fusion against the self, it is not clear what makes the difference between a normal and a neurotic use of these two mechanisms.

It may be assumed that the derivatives of the id are reaching consciousness if their energy cannot be discharged without a coordinated action of the total personality. In other words, the act of consciousness seems to take place whenever an unconscious discharge of instinct-tension becomes impossible. In this respect, the act of consciousness represents an improvement in the method of discharge of instinct-tension and takes place in order to achieve such a discharge. If this statement is correct, any inhibition of the act of consciousness would prevent or delay instinct satisfaction and would take place whenever instinct satisfaction became dangerous. One could then arrive at the conclusion that inhibition of the act of consciousness takes place to prevent instinctual discharge, if this discharge represents a threat to the individual. Before accepting this statement, it must be remembered, however, that the act of consciousness, while serving or facilitating the discharge of the instinct-tension, is not identical with the act of discharge. After unconscious derivatives become conscious an individual is *free* to decide whether a discharge should or should not take place. In other words, instinctual discharge can be stopped in spite of the fact that tension has become conscious (Condemnation —*Verurteilung*). Therefore the suggested conclusion that the inhibition of the act of consciousness takes place to prevent such a discharge was incorrect. Furthermore, it is well-known that an instinctual discharge may take place without its need becoming conscious and that the act of consciousness may lead to a conscious repudiation of the previously unconscious discharge. In other words, the act of consciousness may be used to facilitate, or to prevent, an instinctual discharge on a level on which the individual is aware of what takes place.

What are the advantages of an instinctual discharge either being stopped or taking place on a conscious level, as compared to

the unconscious one? Finding an object, selecting time and way, directing the "aim" in which the satisfaction takes place, co-ordinating the actions required, utilizing memories of former satisfactions, and anticipating future satisfactions, are characteristic of activities on the conscious level. On the other hand, an unconscious discharge or inhibition will take place without the benefit of these elements.

In comparing the conscious and unconscious methods leading to instinct satisfaction one has to remember that the act of consciousness is not a pure intellectual process but that it often contains, in addition to intellectual elements, the emotional sensation of pleasure or unpleasure. The unpleasure is, first, a signal calling for attention by the individual and informing him that his instincts call for discharge; second, it is an emotion he experiences when he remembers previous frustrations and anticipates new ones. If he is able to find the external object necessary for his instinct-satisfaction, his unpleasure will be of short duration. If, however, an external object is not available and an instinctual discharge is impossible (even if one modifies his aim in accordance with external reality), the act of consciousness seems to have no advantage whatsoever. Therefore, it appears that, under such conditions, the act of consciousness will only lead to the experience of unpleasure and will therefore be avoided. As long as there is a possibility of satisfying instincts by modifying their aims or by changing external objects, it "pays" to use the act of consciousness for the selection, guidance and control of impulses. If, however, a modification of aims or change of external objects cannot supply the instinct satisfaction, one may use the mechanism of suppression, by which a conscious elimination of the unpleasure takes place for the time. As a result, the knowledge of the presence of certain emotions, ideas and sense-organ perceptions is avoided. However, this relief is temporary in nature. It appears that suppression is the act of the conscious part of the ego, repression an act invoked by the unconscious part of the ego. In suppression, unpleasure is not only avoided, but the recognition that something has to be avoided is kept from the ego.

According to Freud, the ego has the power to avoid the unpleasure connected with consciousness of the needs of the id, with admonitions and prohibitions of the super-ego and with demands from the external world. It does so by withdrawing the energy

attached to unpleasure-producing representatives. This is achieved, under normal conditions, by the mechanism of *suppression* which, because it takes place on a conscious level, remains reversible.

However, while, in the case of *suppression,* the libido (or destrudo) is transferred from the unpleasure-producing representatives to others which promise pleasure; such a transfer of libido probably does not take place in the case of *repression.* Clinical experience seems to show that repressed impulses retain their libidinal charge. This leads to the question about the method by which the neurotic defense mechanism keeps highly charged derivatives from becoming conscious.

The energy of the instincts used by the neurotic defense mechanisms for contracathexis is used to keep the energy of the repressed wish from becoming conscious, but it is not quite clear why the energy used for the purpose of defense also remains unconscious. To understand the "iron curtain" separating the conscious part of the ego from the unconscious, one must look for a dynamic factor.

A survey of the psychoanalytic literature shows that some authors assume that the so-called death instincts (not the pure death instinct, Thanatos, which according to Freud is silent) are present in the neurotic defense mechanisms. Under the name of death instincts, they describe all the impulses which instead of being directed toward the external world are turned toward the self. This is particularly clear in the case of aggressive instinct fusion. But even in certain examples of self-love, in which the individual gives up all external objects and concentrates his whole libido on himself, final destruction of the individual takes place. From the point of view of economics, some psychoanalysts assume that when the instincts are turned against the self as a result of a neurotic defense mechanism, object libido (or destrudo) does not change into secondary narcissistic libido (or destrudo) but regresses to the primary narcissistic level.

However, most psychoanalysts agree that the study of the various neurotic defense mechanisms shows that the patient treats an external object as if it were part of his own body and his own body as if it were an external object. Metapsychologically, this is expressed as follows: The representatives of the body are cathected by object libido (or destrudo), the representatives of external objects are cathected by secondary narcissistic libido (or destrudo).

This seems to be the result of the mechanism of regression and fixation which is described by some authors as one of the unconscious defense mechanisms. Independently of this terminological question, most psychoanalysts agree that whenever a repression or a denial takes place, the libido (or destrudo) of the warded-off derivative becomes fixated, or regresses to an even earlier stage of development. If, for instance, a child experiences a trauma during the phallic stage, his libido may either become fixated to this stage, or it may retreat to the anal stage and become fixated there. As a result of regression and fixation, the libido does not progress to the next stage of development. A patient of the writer's, who had preserved in his unconscious an infantile oral wish, wanted to satisfy his hunger by devouring the breast of his mother and expected to achieve this aim by merely wishing. As a result of this unconscious wish and the defense against it, he used to suck his tongue. In that way, he behaved as if his tongue were an external object. At the same time, he treated his girlfriend as if she were part of his body. Whenever she disagreed with him, he felt as if he were paralyzed. He expected her to be able to "read" his thoughts and fulfill all his wishes at once.

This writer is in agreement with analysts who differentiate between unpleasure due to tension caused by a sexual instinct and tension caused by an aggressive instinct. A boy who insisted on eating his sandwich during a school lesson instead of during the recess did it not because he wanted to gratify his sexual oral wishes but because he suffered from having to obey and wanted to eliminate this unpleasure by defying his teacher.*

A patient who objected violently to lying down on the couch and enumerated all the reasons against it, lay down at once when the writer succeeded in interrupting his tirade by saying that he might remain seated. It seems that whenever aggression is involved, being forced, or forcing somebody, becomes an important aim.

In translating unconscious material into conscious, one must, therefore, show the patient, not only what he wants, but also how he intends to get it (by force or by agreement).

To the psychoanalyst, it appears as if there were two ways of living one's life. A way often referred to as rational is the way

*Eidelberg, L.: The Attraction of the Forbidden. In: Studies in Psychoanalysis. P. 129. Nervous and Mental Disease Monograph 75. New York. 1948.

in which one tries to recognize the internal and external facts and arrive at decisions on the basis of knowing what can be known. The other way of life is the neurotic one, in which a person *avoids* the knowledge of certain facts (genuine lack of knowledge must be, of course, distinguished from lack of knowledge caused by repression and denial).

Comparing the two methods, it seems that the former (rational) method increases the chances of optimal satisfaction at the price of experiencing temporarily the unpleasure caused by the *knowledge* of certain facts which the latter procedure seems to avoid perceiving. From a scientific point of view, the first method appears to be the better one, because the scientist refuses to live in a fool's paradise, having decided arbitrarily that knowledge is of supreme importance. The therapist who uses science to help the sick is also in favor of the first method, because, as a result of his experiences with his patients, he has the impression that the amount of unpleasure they avoid by being neurotic is smaller than the pleasure they miss. He is, however, prepared to admit that his statement holds true only in cases of patients who have been cured, and he accepts the idea that some patients may be wiser to refuse to seek his treatment.

According to Freud, repression is the mechanism which eliminates the knowledge of unpleasure from within, whereas denial frees us from the unpleasure caused by sense-organ perception. However, only the so-called successful repression can eliminate the knowledge of unpleasure completely. Wherever such a repression takes place the analyst will find nothing to examine. As a result, all the subjects of analytic studies are cases in which repression was not "successful."*

Nobody has, as yet, explained why in some cases the repressed wish remains completely "invisible" (successful repression), whereas in others it succeeds in appearing on the surface in a kind of disguise. It may well be that quantitative factors play a decisive role. In this connection, it may be necessary to point out that Freud called repressions successful only if, in addition to psychic derivatives, the so-called somatic ones were also missing. One may also add that the analytical method is unable to prove that a "successful" repression can exist at all.

*It is problematic whether "successful denials" are possible.

The outside world raise objections only to the motoric discharge reactions in the child and does not concern itself with his ideas and affects. It is probable that, ontogenetically and phylogenetically, action precedes ideas and affects. But analyzing, in a slow-motion view, the process in which a wish becomes conscious, and referring to the moment when the three derivatives have been formed one may say: "At first the individual feels unpleasure, a sensation of tension; then he becomes conscious of its sexual or aggressive color; then there emerges the idea of the object capable of removing this tension and the idea of the action that leads to this goal. The unpleasurable sensation of tension is then replaced, by way of anticipation, with forepleasure. Finally the action takes place, if it achieves the desired goal, the tension unpleasure subsides and the end pleasure appears."*

It is assumed that the ego controls the entry of the derivatives of the id into its territory and tries to select among them the ones whose discharge promises the experience of pleasure or happiness.** This function of the ego takes place with the help of the pleasure-unpleasure signal. Whenever a discharge of an instinctual tension may lead to a punishment from the external world or the super-ego, the ego may block the entrance of impulses from the id. By this, we mean that the ego tries to find an object which would, not only serve instinct gratifications, but produce pleasure, be accepted by the super-ego, and be permitted or offered by the external world. Instinct satisfaction may—and often does—take place in spite of objection by the super-ego and prohibition by the external world. As a result of the former, the individual must accept feelings of guilt, while the latter leads to external conflicts and possible punishments. Although, in such a case, total pleasure is diminished, or the pleasure gained is mixed with the unpleasure connected with guilt feelings and with persecution by the external world, many individuals accept this solution. The psychoanalysis of such individuals shows that they behave in that way because their super-egos object to all forms of instinct satisfaction; or they are not aware that modification of their aims or change of their objects may allow the experience of legitimate pleasure.

*Eidelberg, L.: Studies in Psychoanalysis. P. 116. Nervous and Mental Disease Monograph 75. New York. 1948.

**Eidelberg, L.: In pursuit of happiness. Psychoan. Rev., 38:222.

The following process takes place whenever, as a result of the repression, the total personality is split in two and the repressed material cannot enter the conscious mind:

The part of the ego dealing with the forbidden wishes becomes separated from the conscious part or is overrun by the id. From an economic point of view, psychic energy is mobilized and used, not to deal with the problem, which remains unsolved, but to hide it.

According to Freud the trauma responsible for the act of repression (or one may add, that of denial) usually occurs in childhood. Whenever an external or internal stimulus threatens to destroy the mental apparatus of a child these mechanisms of repression and denial may be used as a protection. Consequently most neuroses, even if they develop in grown-ups, are generally regarded as caused by infantile experiences. The traumatic neurosis, however, which may be due to a particularly severe shock an adult has experienced is not necessarily caused by an infantile trauma.

The study of all neurotic symptoms shows the presence of an unsuccessful repression or an unsuccessful denial. It seems that whenever a traumatic wish is repressed or a traumatic, sense-organ perception is denied, something else appears. For instance little Hans* succeeded in repressing his hatred of his father; but, instead, he had to accept his hostility against the horse. A manifest homosexual** may succeed in denying the existence of female breasts, but he has to accept, instead, a passionate interest in the penes of other men. A fetishist*** may deny the lack of a female penis but has to use a fetish to overcome his fear of the vagina.

In other words repression and denial help us to avoid the knowledge of one unpleasure by accepting the presence of another one.† The fact that a patient may fight for many months to avoid the acceptance of an interpretation, in order to protect himself from the unpleasure connected with it, while, at the same time, he is willing to suffer the unpleasure from his symptoms, can usually only be believed after one has seen it.

The neurotic is not a coward, unable to take the unpleasure a normal person would accept. The unpleasure he avoids, often re-

*Freud, S.: Gesammelte Schriften.

**Eidelberg, L.: Studies in Psychoanalysis. 2d edition. P. 3. International Universities Press. New York. 1952.

***Freud, S.: Gesammelte Schriften.

†Eidelberg, L.: Studies in Psychoanalysis. P. 172.

ferred to as traumatic, had, in his childhood, the power to injure, or even to destroy, his mental apparatus. This kind of unpleasure can produce a shock that may lead to loss of consciousness or even death.

The unpleasure the patient accepts instead of the traumatic one he avoids, was "created" unconscioussy by the patient himself and, therefore, protects his infantile megalomania.

It may be difficult to believe that fears experienced in childhood should have the dynamic power to produce a neurosis in an adult or to disturb the sleep of a normal individual seriously. Only analysis can help the individual to recognize that a part of him never grows up, and to appreciate how much of his energy is needed to control his primitive instincts. A patient of the writer's, a well-to-do man and the president of a large company, was afraid for many years to enter by the front door, the building in which he lived. Only in analysis did he become aware that the doorman he was afraid of had no power over him. But as long as he kept on using the doorman as a symbol who represented his father when he was a child, it was very difficult for him not to use the back entrance.

It is impossible to describe the mechanism of repression without mentioning two phenomena which take place in each analysis and which appear responsible for mobilizing the emotions of the patients. They are the transference and the resistance.

According to Freud, transference is a term that covers all the emotions the patient has for his analyst. The survey of the psychoanalytic literature shows that, while some analysts use the word, transference, according to Freud's suggestions, others reserve it for only the emotions connected with the infantile wishes of their patients. These analysts assert that such a differentiation allows the separation of the normal adult feelings of patients —based on present reality—from the emotions due to revival, in the analytic situation, of infantile repressed wishes.

Such a use of the term has the advantage of showing to the patient the part of his personality which has remained infantile and is causing trouble. The patient's recognition that his complaints or desires are not based on what is going on in analysis but that they are expressions of the needs he had as a child will help him not only to recognize part of his unconscious but will also induce him to try to repudiate it.

A woman patient complained because the writer refused to lie down on the couch and have sexual relations with her. At first, she regarded her emotions, caused by the analyst's objections to such an activity, as based on the reality that she had as analyst a man who despised her. When it was pointed out to her, however, that acceptance of her suggestion would probably embarrass her because she was in love with her husband and that she would not want to change her analyst, she produced more associations to the frustration she suffered. In connection with a dream, she remembered how she had suffered while watching her mother feeding a younger brother and she realized that she wanted the analyst to nurse her. As the writer was not only unwilling, but also unable, to play the role of a wet nurse she had to admit that the rejection she had suffered was caused by her insistence on repeating the old conflict in analysis. We owe to Freud the insight that the patient either remembers his traumatic experiences, or repeats them in analysis, or tries to act them out in the external world. For instance a student of the writer's, who, while working with patients, continued his analysis, got concerned one day about the analytical progress of a friend whom he had originally recommended to a colleague of the author. Without discussing this problem with the author, he called up his friend and told her that as she was still not through with her treatment, she should change her analyst. As his friend resented this kind of interference and advised her caller-student to discuss his uncalled-for activity with the writer, it became evident that the advice he had given to his friend was meant unconsciously for himself.

Another patient of the writer's remained silent for quite a while after he had criticized the Viennese cuisine severely. At first he felt that his silence was caused by his justified anticipation of the writer's anger as a result of his criticisms. However, after the analyst had succeeded in proving to him that there was no reason to assume that he was angry, the patient said: "Still I will not open my mouth." At the same time he put his hand on his nose. A few days later, in connection with a dream, he recognized that the act of putting his hand on his nose represented something his mother did when he refused to open his mouth to be fed. By closing his nose, his mother was able to force him to swallow the food she gave him. The situation was repeated in analysis in order to express

fear that the analyst would force him to accept analytical interpretations.

While some analysts use the term, "counter transference," in connection with the feelings the analyst experiences for his patients, others prefer to speak of counter transference only if infantile repressed wishes are involved.

Although the ideal analyst should be free from all infantile feeling, experience shows that this goal is difficult to achieve and that analytic work may mobilize unconscious wishes which otherwise might have remained dormant. Whenever this takes place, the analyst should recognize it and analyze it himself or ask a colleague to do it. A short example as an illustration may be helpful: A female analyst who was treating a patient suffering from ejaculatio præcox forgot her appointment twice when the condition of her patient began to improve. She analyzed her parapraxia and discovered that the restored erection of her patient had mobilized her own, still unsolved penis envy. As a result, the continuation of the analysis of her patient meant that she would be having sexual intercourse with a woman through an unconscious identification with him. Against this forbidden homosexual satisfaction, she fought by mobilizing an unconscious hostility against her patient. After she had recognized the cause of her trouble, she managed to finish the analysis successfully.

While some psychoanalysts use the term, "resistance," for the power which interferes with the progress of psychoanalysis, this writer is in agreement with others who regard resistance as a mechanism which also operates outside the psychoanalytical treatment and prevents the consciousness and assimilation of repressed material.

While transference is analyzed only after it interferes with the progress of analysis, and counter transference is dealt with wherever it is recognized by the analyst himself or his supervisor, the unrelenting analysis of *resistance* represents the most important factor in the analyst's daily work. In analysis, the unconscious material of the patient becomes available only after the power responsible for keeping this material unconscious has been eliminated. This power, named "resistance," must be overcome before real unconscious material can be obtained. The well-known fact that some patients seem to be conscious of their infantile wishes, and have no resistance against their recognition and gratification,

is responsible for the erroneous conviction that such patients have no egos. While it is true that some perverts appear to be conscious of infantile desires and seek their satisfaction, while other patients reject such desires by repression, a closer examination shows that the wishes the perverts accept are not identical with the infantile wishes repressed by other patients. The perverts, too, repress their infantile wishes. The desires of which they approve are not infantile wishes but the results of a defense mechanism. Therefore, in the analysis of perverts, their resistance against their infantile wishes still has to be eliminated.

It is true, to be sure, that the elimination of the resistance of a pervert is technically more difficult than that of a patient suffering from a symptom neurosis. This is in accordance with Freud's statement that one of the most important factors responsible for the removal of resistance is the patient's suffering and his decision to terminate it.

While books on the technique of psychoanalysis desiribe in detail how this is achieved, it may be sufficient to say here that the analyst must change an ego syntonic defense mechanism into a foreign body.

To be effective, the act of conscious understanding must not only be intellectual, but emotional. Most analysts agree that there are many stages or degrees of such understanding and that only after resistance has disappeared, can one feel that the patient has fully attained it.

The analysis of resistance was, therefore, regarded by Freud as the most important part of the analytical technique. In trying to point out to the patient a certain form of his resistance, in isolating it from the normal part of his personality, and in translating its unconscious meaning, the analyst is able to study the different steps necessary to bring back repressed material. Sometimes analytic work appears to be short and dramatic, more often it is a slow and gradual process which may be compared to the growth of grass (or a tree).

The various forms of resistance* may be illustrated by the following schematic presentation:

*Obviously a similar approach may be used in the study of transference and counter transference.

From a phenomenological point of view, one may differentiate between the resistance which is expressed by a prolonged silence, and the resistance which makes the patient talk without interruption. Whenever this kind of talking takes place the analyst will have to prove to the patient (or to himself in case of counter transference) that silence is not caused by lack of material ("There is nothing in my mind," or "I told you everything I know."), but that it represents an attempt to make the analysis impossible . Some analysts are silent when they should talk; or they talk when they should be silent, because, as a result of their counter transference they are afraid to give an interpretation, because they are afraid of the patient. Only after both patient and analyst have recognized that the patient's silence, or his uninterrupted talk, is not due to conscious reasons, will he be interested in searching for unconscious data.

From a systematic point of view, one may differentiate between conscious and unconscious resistance. In analysis, we are chiefly interested in making unconscious resistance conscious. A patient of the author's, who had been in analysis for over two years and who knew a lot about analytical terminology, surprised him one day by saying that he had no resistance to this treatment because he liked it. Only after a long discussion in which the writer finally succeeded in reminding him that in addition to a conscious resistance there is also an unconscious one, did he recognize that his statement represented an unconscious provocation. He wanted unconsciously to make the analyst believe that he was feebleminded and, therefore, unsuitable for analytic treatment.

From a dynamic point of view, one must separate the repressed material from the repressing factor. A patient refused to describe her masturbation fantasies. In order to overcome this resistance, the writer had to show her that the refusal which appeared to represent her modesty was based on unconscious reasons. The analysis in this case disclosed that it was caused by her unconscious fear of being overwhelmed by sexual desires and forced to masturbate during her analytic session. Another patient who had a similar difficulty was unconsciously afraid that discussing his masturbation fantasy might lead to deprivation of this outlet. The former resistance chiefly served the repressing tendencies, the latter, the repressed wishes, of the patient.

From an economic point of view a separation of the aggressive and the sexual (negative and positive) forms of resistance appears to be advisable. A female patient who kept on describing how she would enjoy having sexual relations with the writer was finally able to understand that her desires were not aroused by the author's sex appeal but represented her resistance to the recognition of an unconscious aggressive wish—a wish to humiliate the writer by rejecting him if he had accepted her offer.

From a topographic point of view, one may try to find in each example of resistance the part which represents the id, the ego and the super-ego. A patient who kept on being late was finally able to give up this form of resistance after the following interpretations were accepted: Being late meant, from the point of view of the id, "I want to stay in bed and masturbate"; and from the point of view of the ego, "I want to decide when I will start my work." From the point of view of the super-ego, being late represented a punishment because of the loss of time.

In some cases it may be possible to see that *one* of the three interpretations has been specially important and decisive in eliminating the resistance of the patient. Whenever this takes place, one may infer that this quantity of the resistance is caused by the amount of libido located in one of the three parts of the total personality. While in many cases, such a quantitative evaluation may be impossible, and while some analysts refuse to tell the patient about the structure of the human mental apparatus, an omission of any *one* interpretation may interfere with the analytical treatment.*

This writer has the impression that one may separate resistance to the content of a certain wish from resistance to recognition of a narcissistic mortification connected with it.

For instance a patient who kept accusing the writer of despising him and of forcing him to be analyzed had little resistance to recognizing that his accusations were an unconscious defense against the recognition that he could not control the scorn he had for the writer. His accusations, by giving the writer a power he did not

*This writer is under the impression that in addition to the three libidinal types described by Freud a fourth one could be accepted. In this fourth type, the greatest amount of psychic energy is concentrated in the sense organs, and most decisions are dominated by the external world. Consequently, in addition to the three interpretations described above a fourth one could be added: "You have to wait, not I."

have, thus were a denial of his own lack of power over himself. However, his resistance increased before it was eliminated—this only after he had recognized that his accusations that the analyst hated him were also an unconscious wish to be loved by the analyst.

Another patient, however, who also accused the writer of hating him and of forcing him to come to be analyzed, developed a great resistance against accepting the interpretation that he accepted the analyst's "orders" to avoid admitting that he had to obey his aggressive desires. On the other hand, he showed less resistance against the recognition that his hostility represented a defense against his unconscious love.

Most analysts agree that resistance should be approached from the surface and that there is no point in giving an interpretation as long as the patient does not consider his behavior to be an expression of his resistance. If a certain interpretation appears to be correct, the opposite interpretation should then be incorrect. However, an interpretation may be incorrect at a certain stage of analysis, or in connection with a certain symptom, and make sense on a deeper level.

Sometimes lack of resistance may cover a resistance which a patient of the writer's aptly named "denial by acceptance." This patient would sometimes accept an interpretation even before the writer had finished the sentence interpreting it. The aim was to avoid a discussion leading to a possible understanding and assimilation of the suggestion.

Another patient had the habit of fighting the analyst energetically. For a long time his analysis made no progress because of prolonged discussions. One day when it was attempted to explain to him the difference between a "possible" and a "probable" defeat, he insisted that such a differentiation could only be understood by a scientist (which he wasn't). Attempts to show him that, in daily business deals, he separated offers with a "possible" profit from offers in which a profit was "probable" failed completely to impress him. His resistance was finally eliminated when it occurred to the writer that he was unconsciously making fun of him by making him believe that he could not think logically.

While it appears impossible to present a complete list of the various forms of transference and resistance it may be advisable to add three examples which illustrate that, not the *localization* of a symptom, but the content of the regressed wish, is decisive.

A patient who used as his form of resistance a kind of mumbling which made the understanding of what he said very difficult, gave this up when it became apparent that it represented the satisfaction and the frustration of his oral wishes and that the analyst represented his pre-Oedipal mother.

Another patient who used to stammer whenever the analysis became too unpleasant got over his stammer when its anal origin was discovered.

A third patient, a woman who used to lose her voice at certain stages of her treatment overcame her aphonia when her penis envy —caused by certain traumatic experiences at the phallic stage of development—was brought into the open.

Transference, as it has already been said, represents the transfer of infantile emotions to the analyst, as a result of which the analyst becomes the person responsible for the traumatic events of the patient's childhood. According to the needs of the patient, the analyst may represent father, mother, brother or sister and may change the role he plays during the treatment.

Most analysts agree that it is impossible to analyze a patient who is unable to produce transference. However, while Freud originally had the impression that only a positive transference could be helpful, he later recognized that one could also analyze patients who had negative transferences and that a positive transference could sometimes become a resistance. While ability to deal with the various forms of resistance and transference has increased, it is still impossible to work with a patient who refuses to co-operate in a critical examination of these two phenomena. While it seems impossible to analyze a patient who is unable to produce transference, it is equally impossible to obtain unconscious material without analyzing resistance.

Transference seems to be caused by the patient's needs to discharge his infantile wishes and his interest in finding objects suitable for this discharge.*

The analyst is a suitable object because he is ready, during his work with his patients, to forget about his own problems and to concentrate completely on the patients. Whenever the patient tries to discuss, in his analysis, the personal problems of the analyst, the analyst will try to show to the patient that what matters is

*People free of repressed infantile wishes may, therefore, be unable to be analyzed.

not what the analyst feels but what causes the patient to speculate about these feelings.

This rule, like other rules, should not be taken literally. A short answer may sometimes be justified and a dogmatic insistence on analyzing each question of the patient may arouse unnecessary hostility. In dealing with transference and resistance the analyst needs common sense, tact and patience, in addition to his interest in the study of the unconscious.

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COMMENTS ON SOME ASPECTS OF THE CURRENT (1953) RESEARCH PROGRAM OF THE NEW YORK STATE PSYCHIATRIC INSTITUTE*

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The aim of research at the New York State Psychiatric Institute is the maintenance of a program of investigation into the problem of mental disorder in terms of the total functioning of the individual. It is obvious that such a program transcends any single scientific discipline or method, and that it must include the efforts of many competent specialized workers. It is psychobiological in the broadest sense of the term, and the following account includes only a few of the procedures and investigations that are currently under way and actively productive. Its object is to present some samples and types of studies in the basic sciences that are of particular importance in modern psychiatric research.

To begin with the division of experimental psychiatry, there are different psychosurgical procedures under investigation including topectomy, medial lobotomy, precoronal lobotomy, and temporal lobe operations, in an attempt to establish the value of these operations. It has been found that the small or limited operations are sufficient for the improvement of many well-preserved schizophrenic and chronic psychoneurotic patients. The psychosurgical results are far superior, with practically all the operations used, in chronic neurotic and pseudoneurotic schizophrenic patients, than in the chronic and especially deteriorated schizophrenic patients.

During operation, electrical stimulation of the cortex is performed to ascertain what electro-encephalographic changes occur under the influence of such stimulation; and the mental behavior is also studied during this stimulation. These patients are operated on under local anesthesia. Investigations disclose that some psychophysiological functions may, perhaps, be localized in certain parts of the frontal lobe. Higher emotional and intellectual functioning, however, cannot be localized in specific parts of the frontal lobe.

Investigations with ultrasound techniques have been started. Apparatus has been constructed which is able to penetrate the brain to produce circumscribed lesions in it. This work will have

*This paper was delivered at the bimonthly conference of the New York State Department of Mental Hygiene at the New York State Psychiatric Institute, New York, N. Y., March 11, 1953.

to be experimented with further on animals before it can be used on humans. The advantage of this method would be to produce lesions in the brain through the unopened skull.

The department is engaged in extensive investigations on experimental psychoses. Mescaline, lysergic acid, and a number of other compounds are used for this purpose. The search is actually for a model of how these substances produce psychoses, which would necessitate the knowledge of how certain drugs are absorbed and act on the nervous system, and of how they are eliminated. It is hoped that the influence of these compounds on the metabolism of the nervous system can be clarified to allow the psychotic manifestations produced to be better understood. As the mental changes produced by these drugs are strikingly similar to those seen in schizophrenia, it is possible that they will yield some insight into the pathogenetic mechanisms of that psychosis. Psychodynamic studies in patients under drugs indicate the great importance of anxiety and tension, seemingly at the root of many complex mechanisms such as aggression, depression and paranoid behavior.

It was found that sodium amytal and pervitin, mixed, act as an antidote against psychotic manifestations produced by mescaline and lysergic acid and probably even have a preventive value. Patients who receive sodium amytal and pervitin prior to administration of mescaline do not develop psychotic manifestations during the period they are under the influence of amytal and pervitin. Mescaline and lysergic acid were found to produce psychoses in "normal" individuals, in schizophrenics and in latent schizophrenics. They magnify and underscore the already existing symptomatology and are able to precipitate gross psychotic reactions in individuals with mild and subtle symptomatology.

Carbon dioxide treatment was investigated in a number of patients. It was found that it can be used as an auxiliary to psychotherapy similarly to such other procedures as sodium amytal and ether, but that it is not the specific organic treatment that has been claimed. It is fairly certain that its therapeutic efficacy is rather limited.

The department of experimental psychiatry is engaged in bringing together all the material on pseudoneurotic schizophrenics. This will be published as a monograph. Besides the clinical and theoretical concepts, it will also include a follow-up study on the outcome of the disorder in pseudoneurotic patients and an evalua-

tion of therapy. To some extent, psychotherapy is effective in these cases. Most impressive in the severe ones, are the results with psychosurgery (small operations) which relieve many of these patients of their crippling symptoms. Shock therapy (insulin and electric shock) has very little effect on this form of schizophrenia.

The current research activities of the department of medical genetics proceed along four concentric lines of approach toward the exploration of basic biological variations in the ability to maintain a state of physical and mental health under varying conditions of stress. The four projects are organized as (1) longitudinal twin sibship studies concerned with the genetic aspects of pre-adolescent schizophrenia, (2) familial forms of mental deficiency, (3) variable resistance to tuberculous infection, and (4) adjustment and survival in the period of old age. The first two projects are recent additions to the research program, the objectives of which were the topic of the 1952 series of the Salmon Memorial Lectures, and they are conducted in part in co-operation with the Bureau of Environmental Studies of the United States Public Health Service.

In the study of pre-adolescent or childhood schizophrenia, the emphasis is on the procurement of comparative family data, which are expected to throw some light on one of the haziest sectors of modern psychiatry. The main question here is whether, and under which particular circumstances, a true schizophrenic process may manifest itself at a very early age, and then predominantly in boys, although the maturation period of the female precedes that of the male. For the statistical analysis of this problem, it will be necessary to investigate whether the usual sex ratio prevails among the children of parents whose offspring include a person distinguished by a genetically-determined vulnerability to certain forms of mental disorder. If the sex ratio proves to vary from one group of family units to another—and there are some indications of such a trend—an entirely new approach will be open to research in the biological phenomena of human personality development.

Two topics have occupied most of the activity of the department of research psychology during the past year. These are (1) the development of several simple psychosensory and psychomotor tests as indicators of the efficiency or lack of efficiency of the central nervous system, and (2) the organization of a project dealing with the psychological prognosis in early and chronic schizophrenic

patients. The first of these problems has been facilitated by grants from the Carnegie Corporation of New York and the Rockefeller Foundation while the second is operating under a five-year grant from the United States Public Health Service.

The general idea that simple tasks might reflect the efficiency of the nervous system has a long and honorable history. The method was initiated in the psychiatric world by Kraepelin who sponsored a long series of such investigations. The mental examination which forms part of most psychiatric case histories contains many such items: Add or subtract serial sevens, repeat digits forward and backward, recount a story, etc. These tests were never too well-standardized and today are used only for suggestive purposes.

The development of newer technical methods, particularly those depending on electronic equipment make it possible to measure and record today with an accuracy far beyond that available a half-century ago. The development of statistical methods which can be applied to the performance of each individual in place of the analysis of data obtained from groups of patients also opens new possibilities. Lastly the concept of testing the reactivity of a single patient to mild transient physiological stress induced by chemical agents, anoxia or exercise, opens up new avenues of approach.

The work on these simple tests has been limited, so far, to reaction time, attention time, speed of tapping, finger dexterity, the critical threshold for flicker-fusion and high tone auditory thresholds. The work is all in progress. Much preliminary investigation has been completed. Several models of test equipment have been made and are being used. The schematic diagrams of the next series of special apparatus have been devised. During the course of several years to come it is believed that equipment, methods and standards will become available for everyday clinical use.

The purpose of the second project is to undertake a biometric analysis of early and chronic mental patients with the view of relating the measurements to their status at the end of a five-year follow-up. The following areas of behavior are to be sampled: (1) sensory, (2) perceptual and (3) conceptual. As a result of previous experience with patients undergoing psychosurgery the opinion has been formed that chronic patients who are poorer in their conceptual than in their perceptual abilities are likely to improve,

while those who are better in their conceptual than in their perceptual abilities are likely to remain in the hospital. In early schizophrenia, those patients who are but little affected in these capacities tend to improve, while those who show considerable lowering in their capacities tend not to improve.

In order to follow through the implications of this observation, four types of patients are investigated: (1) patients applying for psychoanalytic treatment who are considered unsuitable for psychoanalysis because of latent psychosis, (2) admissions to the Psychiatric Institute, (3) admissions to a state hospital, and (4) chronic mental patients who have been ill for approximately two years. It is believed that the results of this study will provide prognostic base lines for the probable outcome of mental illness.

In the department of bacteriology, the application of discs containing aluminum hydroxide cream to the cerebral sensori-motor cortex of Macaca mulatta monkeys has proved an effective method for the production of chronic epilepsy. Previous studies in this department have indicated that section of the corpus callosum, or contralateral pre-central motor cortical ablation, increased the convulsive response to aluminum hydroxide cream placed on one cortex. Consequently the workers are now engaged in evaluating the effect of ligation of contralateral cerebral arteries.

The middle cerebral or the anterior cerebral artery will be ligated intracranially near its origin from the circle of Willis. For each ligation groups of animals will be operated upon (1) before, (2) simultaneously with, the application of aluminum hydroxide cream, and (3) after the onset of seizures. Clinical examinations, serial EEG tracings, and motion pictures will be made at intervals, as well as neuropathologic studies at autopsy.

Since previous work in this laboratory suggested the existence in the pre-central motor cortex of the monkey of inhibitory fibers or mechanisms whose interruption at the cortical or callosal level facilitates convulsive reactivity, it is believed that functional interference with masses of contralateral cerebral hemisphere tissue may lead to an increased convulsive response. The results may indicate the role of impaired blood supply to the contralateral hemisphere in epilepsy, especially epilepsy of focal cortical origin. This has special interest because of the high clinical incidence of (a) epilepsy and (b) cerebrovascular accidents. It is believed that the data obtained on the influence of contralateral structures upon

focal cortical epilepsy will be of importance in evaluating the pathophysiology of epilepsy.

The department of neuropathology is presently engaged in two major investigations: (1) the production and prevention of experimental allergic encephalomyelitis in laboratory animals and (2) the evaluation of cerebral structural and histometabolic changes in schizophrenia.

The experimental allergic encephalomyelitis carried on in the department of neuropathology dates back to 1938 and was related to confirmation and further elaboration of the work of Rivers and Schwentker on the production of encephalomyelitis following intramuscular injections of brain suspensions. Subsequently with Freund's modified technique, the encephalomyelitic process, which took several months to a year to be induced with the Rivers method, could be precipitated with this new procedure within a few weeks. In attempts to detect the allergen responsible for experimental allergic encephalomyelitis, extracts of brain proteins, lipids and brain proteolipids have been found capable of producing encephalomyelitis. A basic contribution from the department on the pathology of human demyelinating diseases viewed as an allergic reaction of the brain established, apparently, the analogy between the pathologic processes of human demyelinating diseases and the pathologic processes of experimental allergic encephalomyelitis. While new avenues of exploration for the production of experimental allergic encephalomyelitis are in progress, the investigators are also interested in the prevention of this disease. Several approaches were used such as intramuscular and intravenous injections in the experimental animals of normal brain tissue, various dilutions of proteolipids, and hyaluronidase with the purpose of modifying the colloidal status of the antibodies, thus lessening pathological effect.

Additional biopsy from topectomies and postmortem material is being investigated in relation to the evaluation of cerebral histopathologic changes in cases of schizophrenia. From the study of a large number of cases one is impressed with the fact that, in the presence of cerebral structural changes in cases of a schizophrenic syndrome, one must evaluate first the following possibilities before reaching the conclusion advanced by some investigators that schizophrenia is an organic brain disease: (a) The morphologic changes may be the expression of complicating organic or bio-

chemical processes which may have developed during the course of the life of the patient after the onset of the schizophrenic symptoms; (b) the morphologic changes may be due to a primary organic brain disease which may have precipitated a schizophrenic syndrome; and (c) the morphologic and histometabolic changes may be the expression of a psychosomatic integration which results from the reciprocal interdependence of soma and psyche.

The department of pharmacology has continued its research program relating to amino acid and peptide metabolism in the central nervous system with particular attention to the metabolism of glutamine and glutamic acid.

The enzyme, glutamotransferase, which was discovered some years ago in this laboratory and which is assumed to play a role in the initiation of peptide and protein synthesis, has been highly purified, with brain as source material. The requirements of the enzyme for full activity were studied. It was found that it needs adenosine triphosphate in minimal amounts. These amounts are so small that a new role as a co-enzyme is suggested for adenosine triphosphate, which has, up to now, been assumed to act mainly as a source of biological energy. In the present studies, much emphasis is put on this point, since it is hoped that if the mechanism of this activation is understood, it will clarify, not only the mechanism of the action of this enzyme, but will also form a bridge between peptide synthesis and nucleic acid metabolism.

The formation of this enzyme has been studied during embryonic development. This plan of approach is pursued because it is felt that abnormalities of mental function in adult life may relate to enzymatic disbalance occurring during the embryonic development of the central nervous system. A preliminary study of glutamotransferase in the developing brain of the chick embryo has been completed. It could be shown that although the enzymatic pattern starts much later in the brain than in the liver, the concentration of enzyme at hatching is as high in the brain as it is in the liver.

A detailed study of the enzymatic conversions of the tripeptide, glutathione, is being carried out. It has been found that there exist enzymes in brain which transfer the glutamic acid moiety of the tripeptide glutathione to other amino acids whereby glutamic acid peptides are formed. A hypothesis regarding the role of these

mechanisms in peptide and protein synthesis has been outlined. In the framework of this hypothesis the enzyme systems in the central nervous system responsible for the synthesis of glutamine and glutamic acid are under close scrutiny. One of the goals of this research program is the development of understanding of amino acid and peptide metabolism of the central nervous system, to a degree which will make possible the preparation of drugs which may influence the abnormal metabolism of nitrogenous compounds. A number of such preparations have been, and are being, developed in the laboratory, and they will be put to test in the near future.

The department of biochemistry is engaged in an investigation of brain metabolism based on the procedure of Geiger and Magnes for the perfusion of the brain in the living cat. With this technique, a wide variety of experimental procedures may be applied. For example, substances may be added to the perfusion blood and circulated through the brain, the composition of the perfusion blood may be modified, and the brain may be stimulated electrically, or by drugs such as metrazol. The effects of such procedures may be measured by physical methods, such as the electrocorticogram and the response of the animal to physical stimuli, and by chemical analyses of inflowing and outflowing perfusion blood, of small biopsy samples of brain tissue, and of part or all of the brain at the end of perfusion.

Of the several studies to which the procedure has been applied, there is space to mention only one, as an example. One of the fatty acids, octanoic acid, labeled with radiocarbon, was perfused through the brain for a period of about five minutes. After the labeled substance had been washed out of the blood vessels, the brain was removed, and the lipids were extracted and fractionated. The radioactive C_{14} label was found in all of the lipids except cholesterol. Even purified cerebrosides contained small, but highly significant, amounts of C_{14}. One small fraction with the solubility characteristics of triglycerides (ordinary fat) was highly active. Attempts are now in progress to separate and identify the active constituents of this fraction by means of the countercurrent distribution method. These findings show that octanoic acid can penetrate into the brain; they indicate, contrary to current teaching, tnat there is a considerable metabolism of lipids in the brain; and

they open up the possibility of determining the pathways through which lipids are synthesized and broken down in the brain.

There are a number of clinical psychiatric researches under way that are interesting and promising. They will be reported in detail on another occasion.

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FRUSTRATION-AGGRESSION HYPOTHESIS EXTENDED TO SOCIO-RACIAL AREAS: COMPARISON OF NEGRO AND WHITE CHILDREN'S H-T-P'S*

BY EMANUEL F. HAMMER, Ph.D.

The concept of frustration and the problem of emotional reactions to it have recently come in for a large share of scientific attention. This is so not only in the cases of experimental and clinical psychologists, psychiatrists, and psychiatric social workers, but also in those of sociologists, social psychologists and educators. The volume, *Frustration and Aggression,* written by the Yale group,[1] which may well become a classic, has most clearly focused attention on this problem.

It is commonly accepted that frustration consists of the thwarting or blocking of an individual's significant drives, motives, or needs. Symonds,[2] for example, defines frustration as "the blocking or interference of the satisfaction of an aroused need through some barrier or obstruction." Maslow,[3] however, holds that frustration consists of two aspects: deprivation and personality threat. Deprivation of an ice cream cone for a child, for example, does not necessarily constitute frustration, but when such deprivation is viewed by the individual as representing rejection by the mother who denies the ice cream cone, it constitutes a frustration. Similarly, whereas economic discrimination against the Negro may or may not represent rejection, social discrimination against him must, almost by definition in our culture, represent rejection and, hence, eventuate in frustration.

For the child of Negro race, the outer white world is often found to be full of disappointment, frustration, and threat, both covert and overt. In addition, such a child feels the reflected differences in opportunity and the comparatively meager advantages that are presented to his parents in our present-day American society, as opposed to the greater opportunities and advantages presented to the parents of his white contemporaries.

*From Research Project, New York State Psychiatric Institute. Grateful acknowledgment is made to John N. Buck, for serving as technical and editorial consultant, and to Miss Hannah S. Davis and Mrs. Lila K. Hammer, who, in addition to the writer, served as clinician-judges for the H-T-P's. Further thanks are due Allen Cohen, William Dakos, and Miss Lois Brinkman for serving as supplementary clinician-judges.

A comparison, then, between the relative degrees of aggression in Negro and white children appears to offer fertile research grounds for the extension of the frustration-aggression hypothesis to social and racial areas.

An investigation of this type would appear to have significance also for concepts of psychodynamics relative to the Negro and white groups. Hadley[4] points out that certain approaches to psychotherapy fail to take into sufficient account objective social conflicts as causes of personal conflict. Therefore, the frustration-aggression hypothesis would appear to deserve very careful consideration in evaluating the adjustment level of a Negro patient or subject. Many psychotherapists believe that hostility and aggression assume a decisive role in the difficulties in living for which individuals seek psychotherapy. Fenichel[5] gives much consideration to the varied manifestations of forbidden aggression and hostility as expressed in emotional problems, and Horney[6] espouses the view that aggressive impulses of various kinds form the main source from which neurotic anxiety stems. The etiological importance in schizophrenia of guilt-producing hostility and destructive urges is well known and has received due emphasis from Fromm-Reichmann[7] and the Sullivan group.

The idea of using a projective technique to tap the intensity of hostility in the subjects of the present study grew from a recent study of Bellak[8] which deserves mention in this regard. Ten TAT cards were divided into two groups of five cards each. Subjects made up themes for the first set of five cards and were, thereupon, sharply criticized for the poorness of their stories. Then the remaining five cards were administered with the subject criticized after each of these cards. Analysis of the stories by three judges indicated that the amount of aggression and hostility increased very significantly following frustration. This study suggests the appropriateness of studying the variable of aggression-hostility by the use of projective techniques.

Procedure

The free-hand drawing of House, Tree and Person was used to tap the personality of the Negro and white children in the present study because it represents a quick and easy-to-administer projective technique which seems to be penalized less by group administration than most other projective devices. H-T-P's had been

administered to 148 Negro children* from grades one to eight in a gratifyingly representative (from a socio-economic viewpoint) semi-urban, semi-rural school in Virginia during a previous study.[9] As it was not feasible to attempt to equate a white control group on the same socio-economic level, since relatively few Negroes in Virginia are of a socio-economic level comparable to the majority of the whites, the students of the companion white school in the same community were tested. Group H-T-P's were administered to 252 white children ranging from grades one to eight. Thus, data were elicited with the aim of comparing the two groups as they tend to function in their respective cultural settings.

The 400 H-T-P's were put into random order of Negroes and whites by grade level. The clinician-judges, without knowing whether they were rating drawings made by Negro or white subjects, rated each H-T-P on a scale of aggression from zero to two. A rating of zero represented no apparent aggression or hostility, a rating of one represented mild aggression or hostility, while a rating of two represented severe aggression and hostility. Three clinicians served as judges for the drawings of all eight grades of the Negro and white children, while three additional clinicians served as judges for the third, fifth, and seventh grades in order to afford the opportunities for a spot check.

Correlations of the judgments of the three principal judges were then computed. All six judges, principal and secondary, were put in rank order according to the degrees of hostility they apperceived in the 400 H-T-P's they had rated. This rank order was then compared with the rank order in which the judges were rated for hostility by the writer, who was supervisor of intern training at Lynchburg (Va.) State Colony, which was conducting the study. The supervisor rated the clinicians on the basis of the degrees of aggression and hostility manifested by the clinicians in their interaction with patients and other staff members. The clinicians were placed in rank order of hostility before they judged the 400 drawings; and they did not know of the dual end to which their ratings would be put until after their data were handed in and their consent obtained.

The drawings were rated on the basis of the following qualitative signs for aggression and hostility from the *Guide for Qualitative Research with the H-T-P*:[10]

*By John N. Buck, Miss Patricia Nigg, Mrs. Audrey Mailer and Bernard Meiselman.

The drawing of attic windows which are open implies hostile phantasy which causes the person guilt. It has been observed that subjects who are extremely prone to phantasy in hostile fashion frequently provide themselves with what might be called "safety valves" by drawing open windows in the area symbolizing phantasy thinking, the roof.

Windows drawn without panes, curtains or shutters (hence, like the "key-hole" Tree below, another depiction of unrelieved, enclosed, white space) may imply hostility.

A Tree which consists of a looping line representing the Tree's branch structure (unclosed at its junction with the trunk), and two vertical lines closed or unclosed at the trunk's base (thus resembling a key-hole) is taken to indicate strong hostile impulses.

Two-dimensional branches that are drawn resembling clubs or sharply pointed branches or leaves, especially with little organization, imply strong hostility.

A mutilated Person or a degraded Tree or House, it goes without saying, serves to underscore the patient's hostility. The use of degrading details which serve to symbolize feelings of aggressive hostility may include such depiction as an out-house drawn beside a House that is otherwise a mansion, a large conspicuous garbage can drawn on the front porch, or a dog drawn as urinating against the trunk of the Tree.

Sharply pointed fingers and toes, as well as other similarly treated details, are a reflection of aggressive tendencies, as are teeth prominently presented in the drawing of the face.

Sharply squared shoulders in the drawing of the Person connote overdefensive, hostile attitudes.

Well-outlined, but unshaded hair, in the drawing of the Person suggests hostile phantasy concerning sexual matters.

Arms that are drawn folded across the chest suggest attitudes of suspicion and hostility.

The Person carrying weapons such as guns, black-jacks, etc., clearly indicates aggressive and hostile tendencies.

The Person presented in a threatening attitude (example, fist upraised, etc.) bespeaks aggressive hostility.

Drawings made conspicuously too large for the page, without adequate page space framing them (particularly when they touch or almost touch the page's side margins), tend to indicate a feeling of great frustration produced by a restraining environment, with concomitant feelings of hostility and a desire to react aggressively, either against the environment, the self, or both.

The least objective approach at this stage of the H-T-P's development, Buck[11] writes, is that of interpretations made on the basis of qualitative indications. It is also the most dependent for

its skillful and successful usage upon the experience and capability of the clinician, but it is often by far the most revealing.

The qualitative points listed here were employed as broad guideposts in an effort to increase, in some measure, the objectivity of the qualitative approach employed in the present study. The greater the number of "signs" of hostility and aggression in a set of drawings, the more inclined the clinicians were to go up the continuum from mild to severe in their ratings. Since the dynamic interrelationship of a sign with all other signs available is of prime importance, however, each drawing was viewed as a gestalt. An attempt was made to take the total constellation into account at all times.

Results

As can be seen from Table 1, the mean aggression and hostility rating for all eight grades of white children is .308 which is approximately three-tenths of the distance up the continuum from a point of no apparent aggression and hostility to a point of mild aggression and hostility. The mean hostility rating merited by the drawings of the Negro children is .823, a point approximately eight-tenths of the distance up on the continuum between a point of no apparent aggression and hostility to a point of mild aggression and hostility. Hence, the white children prove to be closer to the point of no apparent aggression whereas the Negro children score closer to the point of mild aggression. A t-score of 12.56 is statistically significant at far better than the 1 per cent level of confidence and indicates that a real difference exists between the degree of need for aggression in the Negro and white groups, with the incidence being higher in the former.

No consistent trends, either absolute or relative, are apparent in the hostility index of the Negro and white children when broken down by grades. Whether a trend becomes apparent when the data are extended into the high school age group is currently being investigated by a follow-up study.

In perusing the drawings for indications suggestive of aggression, the clinicians became aware of a striking incidence of drawings made conspicuously too large for the page, without adequate space framing them. Buck[11, 12] writes that drawings made conspicuously too large for the page, without adequate space framing them, tend to indicate a feeling of great frustration produced by a

Table 1. Comparison of Average Hostility Indices of Negro and White Children by Grade Level*

Grades	White	Negro
1	0.19	0.84
2	0.19	0.88
3	0.38	0.75
4	0.17	0.82
5	0.27	0.81
6	0.44	1.18
7	0.47	0.58
8	0.36	0.73
Mean	0.308	0.823

*A rating of zero represents no apparent aggression and hostility, one represents mild and two represents severe aggression and hostility.

restraining environment with concomitant feelings of hostility and a desire to react aggressively. When the incidence of such drawings was tabulated quantitatively it was found that 10.3 per cent of the white children presented such drawings whereas 28.3 per cent of the Negro children did so. A t-score of 3.84 indicates a statistically significant difference at the 1 per cent level of confidence in regard to this factor. Hence, this quantitative tabulation supports the qualitative judgments of the clinicians that the Negro subjects harbor greater feelings of frustration, with a desire to react aggressively, than do the white.

The correlation between the judgments of clinician X and clinician Y is .84 with a standard error of .014 and a probable error of .009. Correlation between the judgments of clinicians X and Z is .78 with a standard error of .030 and a probable error of .021. A correlation of .74 with a standard error of .031 and a probable error of .020 exists between the hostility judgments of clinicians Y and Z. Thus, correlations ranging between .74 and .84 are found among the three main clinician-judges.

All six clinicians, the three main and the three secondary judges, were placed in rank order in regard to the degree of hostility they manifested in interpersonal relationships as judged by the supervisor. A comparison of this rank order with the rank order of the degree of hostility they saw in the H-T-P drawings of the 400 subjects is presented in Table 2.

Table 2. Comparison of Rank Order of the Average Hostility Indices Given the 400 Drawings by Each of Six Clinicians and the Rank Order of the Degree of Hostility in Each Clinician as Judged by Their Supervisor*

Clinician-judge	Average hostility index awarded the drawings	Rank order** of hostility index awarded the drawings	Rank order** of supervisor's rating	Difference in rank order
A	0.49	1	1	0
B	0.51	2	3	1
C	0.57	3	2	1
D	0.63	4	4	0
E	0.90	5	5	0
F	1.12	6	6	0

*A rating of zero represents no apparent aggression and hostility, 1 represents mild and 2 represents severe aggression and hostility.

**In ascending order.

It can be seen that the supervisor's ranking and the ranking on the basis of the degree of aggression and hostility interpreted from the children's drawings agree perfectly in regard to clinician-judges A, D, E, and F. A reversal is found in regard to clinicians B and C where the supervisor rated clinician B as second and clinician C as third in ascending order of aggression and hostility; on the basis of the degree of aggression and hostility seen in the drawings, clinician B was third and clinician C was second. A rank order correlation of .94 with a standard error of .48 and a probable error of .32 is obtained.

Discussion

If we take as an assumption the view that the Negro child suffers more frustration than the white child, as defined by its criteria of deprivation and personality threat, the frustration-aggression hypothesis when extended to social-racial areas receives support from the present study. This is in accord with a study by Bender[13] in which she found a proportionately greater incidence of childhood behavior disorders in Negroes than in whites. Since aggressive and hostile impulses which tend to be acted out are an important criterion for the diagnosis of childhood behavior disorder, this study and Bender's appear to be complementary. St. Clair,[14] on the basis of extensive psychotherapy experiences with Negroes, writes that hostility is a dominant problem for them and

should receive particular attention during therapy. These studies tend to support the view that racial prejudices and inequalities—oftentimes providing life-long and inescapable frustration—tend to produce aggression as a reaction.

An interesting psychoanalytic view of the Negro's supremacy in athletic competition with whites is congruent with the findings of the present study and suggests a sublimation of some of the aggressive impulses by the Negro who often dares not express them directly. Holloman[15] holds that the motivation for the Negro's drive for supremacy in this area is hatred and a desire for revenge, as well as efforts to compensate for feelings of inferiority.

From a pragmatic point of view it would appear that aggression would be elicited as a reaction on the part of the Negro as long as a caste system exists, whether overt or as a subtle undercurrent, in which he is afforded less opportunity for democratic participation in society than his white contemporaries, and is further handicapped and frustrated in the competitive struggle for achievement and status.

To turn to the question of the correlation of the judgments made by the three main judges, correlations ranging between .74 and .84 suggest a reasonably high degree of reliability among clinicians rating a qualitative factor such as aggression on the basis of the H-T-P. In spite of these reassuringly high correlations, however, it appears that much subjectivity enters into and distorts the interpretation of a factor such as hostility in projective drawings. The supervisor's judgment of the degree of the clinicians' hostility and aggression, as manifested in their interrelationship with patients and staff members, was found to correlate to a marked degree with the proneness of the clinician to see hostility in the drawings of other subjects. This finding may be partly explained by the differences in *sensitivity* on the part of the various clinicians to the particular personality factor, aggression. In addition, the differences among the clinicians' interpretations on the basis of the projective technique are probably further due to the fact that, when interpreting a projective technique, clinicians tend to *project* as well as interpret. This appears to be supported by both (1) the high correlation between the writer's ratings of hostility in the clinicians and the degree to which they saw hostility in the 400 H-T-P's they interpreted; and (2) the fact that clinician F, for instance, awarded the drawings an average hostility index which ap-

proaches the point of being twice the mean hostility index awarded by the other five judges.

Summary and Conclusions

Four hundred H-T-P's were administered to Negro and white children ranging in grade level from first to eighth. The drawings were put into random order of Negroes and whites by grade level. Six clinicians, without knowing whether they were rating drawings by Negro or white subjects, rated each set of drawings on a scale of aggression consisting of three points: none, mild and severe. The six judges were put into rank order on the basis of the degree of hostility and aggression they apperceived in the 400 H-T-P's rated. This rank order was then compared with the rank order in which the judges were rated for hostility by the supervisor on the basis of his observation of their interaction with patients and staff members.

Since the results of the study were obtained from students in two schools of one community, the validity of the results should be tested on other pairs of comparable groups. However, the following tentative conclusions (the further validity of which can be established only by studies in other geographic areas) seem justified.

1. The mean aggression and hostility rating earned by the drawings of the white group of school children is significantly lower than that of the Negro children. The drawings of the Negro children suggest greater feelings of frustration produced by a restraining environment, with concomitant feelings of hostility and a desire to react aggressively.*

2. If the assumption is accepted that the Negro child suffers more frustration than the white child, as defined by its elements of deprivation and personality threat, then the frustration-aggression hypothesis, when extended to the social-racial area, is supported by the present study.

3. There is a reasonably high degree of reliability among the clinicians who served as judges in the present investigation in their ability to judge the degree of aggression and hostility as manifested in a subject's free-hand drawing of a House-Tree-Person.

*This aggressive potential may be directed outward against the environment, inward against the self, or both.

4. In spite of this relatively high degree of reliability, the clinicians' interpretations were, in part, determined by their own projections.

5. As suggested in a previous study,[9] the relatively greater incidence of aggression and hostility found in a "normal" sampling of Negro children suggests that the clinician must be cautious in interpreting the projective protocols of a Negro subject. In evaluating the severity of a record, two different and somewhat antithetical frames of reference invite equal consideration. It is necessary to keep in mind the concept of relativity in regard to other members of the same race, while simultaneously keeping faith with the concept of a baseline representing an optimum or ideal state of personality adjustment—regardless of how many others of the same race are similarly suffering from the particular neurotic symptom.

6. More extensive studies of comparable white and Negro populations, in different geographic areas, should be undertaken with particular emphasis upon analysis of the total personality.

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PSYCHOTHERAPEUTIC APPROACH TO SCHIZOPHRENICS THROUGH INSULIN-COMA TREATMENT*

BY DÉSIRÉ ANNAU, M. D.

It is almost generally agreed that Sakel's insulin-coma treatment is, at the present time, the best treatment available for schizophrenics. It gives the best results mainly in the paranoid form of schizophrenia, where other methods usually fail to give lasting improvement.

In spite of the recognized good results, its mechanism of action is still much debated and obscure. Sakel himself believes in a specific metabolic action that regulates the hypothetic metabolic disturbances of schizophrenics. He does not believe in additional psychotherapeutic action, and warns against any other types of shock treatment, considering them as harmful to the brain and nerve tissues. This conservative viewpoint and the specific action claimed are much contested by most other observers.

These other observers deny the superiority of the insulin-coma treatment *per se* and believe that the better results obtained with it are due to the accompanying intensive nursing care. These workers believe that the sympathy, effective help, and friendliness experienced during the treatment help the patients to regain their faith in other people's good will, disperse their resentment, assist them in giving up their isolation and offer them many occasions to overcome their shyness and fear of associating with other people. Experiments to clarify this point have been performed by placing two groups of patients under the same conditions of treatment and care. One group received insulin, the other sterile water injections. The result was that the patients receiving insulin showed the usual improvement rate, the others' conditions fluctuated as those of schizophrenics without treatment. This experiment demonstrated that the special care of the insulin patient is not the only curative factor, but did not prove that the insulin's metabolic action is the sole factor involved. The profound subjective sensations during insulin treatment are psychological factors which cannot be neglected. The increasing hunger and thirst, extreme sweating, overwhelming weakness and drowsiness, then the slow regaining of consciousness again are experiences which deeply affect the patient.

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Others believe again that insulin-coma treatment is no more than one of the so-called shock treatments, the better results are only due to the longer duration of the treatment. The importance of the time factor cannot be disregarded. There is no other systematic psychiatric treatment that is commonly applied for such a long period. Only Klaesi's continuous-sleep treatment can be compared; this lasts for about 200 hours, as the insulin-coma treatment does, reckoning from the onset of the insulin reaction to the complete termination of the coma. The essential difference remains that the continuous sleep's duration is about eight to 10 days, whereas the insulin-coma treatment is given for about 60 days.

If one considers the clinical and psychological effects of the various shock treatments, they seem to indicate that each type of treatment sets a characteristic mechanism of its own into action. The prompt and quick relief of the electric convulsive treatment in all types of depressions is above discussion. The involutional and manic-depressive depressions usually disappear after a few treatments, although the results in reactive depressions, without simultaneous psychotherapy, are not so constant, and relapses often occur. In manic states the results are discouraging, unless several daily applications are used. Catatonic stupor is often not influenced by ECT, but quick relief is achieved with a few metrazol-convulsive treatments. The writer has seen quite a few cases where ECT has been without results, but where metrazol was followed by prompt disappearance of the catatonic symptoms. With the Emma modification,* metrazol treatment lost its main contraindication, the fear, terror and panic suffered by the patients. With the addition of 2 cc. of 50 per cent glucose solution, patients take the treatment easily without any apprehension.

Electronarcosis seems to have a specific beneficial action in anxiety states and marked tenseness. It gives prompt relief—better than any sedation. It is often very useful in anxiety neuroses when, because of severe anxiety, the patient is unable to co-operate in psychotherapy. After a few treatments, the patients are usually relaxed enough to enter productive psychotherapy.

Klaesi's, in the writer's opinion, unduly-neglected, continuous sleep treatment's clinical usefulness lies between metrazol and electronarcosis. It calms agitated patients and makes un-co-operative patients amenable to psychotherapy. In the writer's estimation,

*Emma: Psychiatrisch, Neurologische Wochenschrift. 1940.

it is still the best treatment for psychogenic excitement, when "narcoanalysis" and synthesis remain without effect.

All the treatments mentioned seem to act mainly by relieving emotional pressure and liberating patients from overwhelming affective involvement. They make them able to face their problems in a sober and objective manner. Pathological ideation seems to be uninfluenced by these treatments. Involutional depressed patients with paranoid trends are relieved from their depressions, but their paranoid ideas remain unchanged. Often, only after ECT, when the depression is relieved, does the paranoid trend become visible. How deep-seated the emotional changes after treatment are at times has been shown in a letter received a short time ago from the husband of one of the writer's depressed, paranoid patients. This patient had had latent homosexual tendencies all her life, and had remained absolutely frigid during her 17 years of marriage. Before coming to Marcy (N. Y.) State Hospital, she was treated in a private sanatorium with ECT; her depression was relieved and, to the great surprise of her husband and herself, she was able to enjoy normal orgasm. After two or three weeks, however, she slowly relapsed into her depression and again became completely frigid.

It is not the object of this presentation to enter into deeper analysis of the emotional changes during and after convulsive treatments. The aim is only to show that we are far from knowing the mechanism of the beneficial action of these various treatments. Each seems to have its own peculiar action and indication. Clinically, they all seem to act by relieving emotional tension, but have no direct influence on the pathological ideation.

The writer has administered insulin-coma treatments, on a large scale, for about 15 years. At first, he paid no attention to the specific behavior of the patients and was more concerned about general condition, quality of the coma, and neurological and laboratory findings. As the writer had been used to the good rapport and abundant productions during the continuous sleep treatment, insulin-coma did not seem to him to offer any psychotherapeutical material, and the writer believed as Sakel and others still believe, that insulin acts on the metabolism and that its proper application is the sole therapeutic agent. It is true, that during this period, the writer spent only as much time with the patients as was necessary to terminate the comas and intervene in emergencies.

Later on, when the writer witnessed sudden transitory changes in patients' behavior during the postcomatose period, namely, hallucinations, bizarre mannerisms and agitation in otherwise well-composed and not hallucinating patients, or seemingly normal behavior in disturbed patients, he was with the patients during the whole course of the treatment and was rewarded by a wealth of important psychodynamic material.

To illustrate what this material is like and how it can be utilized, a few cases of observations at Marcy will be described briefly.

Case 1

V. R., a 23-year-old woman, described as sensitive and shy but generally cheerful and active, had "gone steady" with one boyfriend for two years prior to her hospitalization, and for about a year had had sexual relations with him. The boyfriend had a, seemingly well-deserved, bad reputation which she disregarded. Her parents frequently warned her and were opposed to this friendship. She would not break with the boy but left her family, rented a room, and there received him undisturbed. They had frequent arguments, the boy missed dates, neglected her at times and showed interest in other girls. She became somewhat depressed and returned to her parents but continued to see the boy. One night after having had intercourse with him, she felt sick, on her return home called her mother, said that something was wrong in her insides, and that she had contracted syphilis. Since that time, she had been constantly afraid that someone was following her. She accused her parents of always interfering in her life, never allowing her to have fun, and of preventing her from marrying her boyfriend because of their different religions.

She received eight electric convulsive treatments in a private sanatorium and was considered recovered, but 10 days later she was admitted to Marcy where she was withdrawn, un-co-operative and actively hallucinated. She exhibited bizarre mannerisms, was emotionally dull, and stood or sat for hours on the same spot, uninterested in her surroundings. She denied there was any reason for her hospitalization and declared that she was brought to the hospital by her parents only to spite her and separate her from her boyfriend. She was soon placed under insulin-coma treatment, and often had spontaneous convulsive seizures, her condition remained

unchanged for a considerable period of time. Repeated interviews did not reveal any new material; she always emphasized her love for her boyfriend and her hate for her parents who wanted to destroy her happiness. She wrote letters daily to her boyfriend, but he never answered and never came to visit her. She explained his behavior by saying that her parents forbade him to have any communication with her.

She went down into coma quietly and came out without any restlessness or excitement. She had a vague smile at times, but said nothing. One day, near the end of the treatment, she came out of coma crying bitterly. As she never had had such an emotional reaction before, she was immediately interviewed and was asked why she was crying. Still sobbing she said that she knew her boyfriend went out with other girls and that that was the cause of their frequent arguments. The day she became sick, she felt sure that he had had intercourse with another girl, and that is why she feared she had contracted syphilis. During this and other interviews, she spoke freely about her doubts and grief over the love of this boy. She admitted that her parents were right when they objected to him, but she felt unable to give him up after she had "sacrificed everything" for him. After these interviews, her behavior changed completely. She became cheerful, mingled freely with other patients, became attached to some of them, cared more for her appearance, and showed much affection toward her parents.

Case 2

E. A. T. is a 26-year-old teacher, separated from his wife. He had always been very closely attached to his mother. His social relations had been, for many years, exclusively with men. He did not go to dances and was shy with girls. He had been in the navy for two and one-half years, during which time he had his first sexual relations with girls. He characterized these girls as oversexed and himself as cold-natured and suffering from quick orgasms. After his honorable discharge from the navy, he finished college. He married a girl in 1950 whom he had known for several years. They never adjusted well to their marital status; he went to his mother daily and she to her parents. During the first weeks of marriage they were unable to carry out intercourse; she was a virgin and he was unable to pass the introitus. Later on they consummated their marriage, but both were dissatisfied. He always

had the uneasy feeling that somebody would surprise them during intercourse. This, he thought, was the cause of his too quick ejaculations. This marriage was annulled after one and a half years, but he claims that he still loves his wife "more than a sister."

Prior to marriage, he had felt tense, nervous, had some difficulty in concentrating and in making decisions and had always felt the need to discuss his problems with his mother. After marriage, these symptoms became more accentuated, and he himself admitted his inability to assume a masculine role. He enjoyed teaching children and was considered a very good teacher. When he was assigned to teach adults, he became afraid, quit his job immediately, and was so upset that he ran around with his car wanting to have an accident and kill himself; but, finally, not having enough courage to do so, he went home.

He was admitted to Syracuse Psychopathic Hospital where he showed catatonic features. He complained about the feeling that his head was split in halves. After a few electric convulsive treatments, he believed that his thinking was clearer and recalled a childhood experience when he was being chased by a little girl who wanted to "neck" with him, but he had protected himself by swinging a chain. In October 1951, he was admitted as a voluntary patient to Marcy. He was retarded, depressed, and perplexed. He repeated, over and over again, his sensations in minute detail, but was unable to give an over-all picture of his condition. There was considerable blocking and inhibition, associations were scattered and illogical. He wanted constant attention and interviews without being able to offer further material. He was soon placed under insulin-coma treatment. Before going into coma, he became fearful, but was calmed when someone was near his bed. When coming out of coma, he was restless, agitated for a while showing marked fear and anxiety, but soon relapsing to his former attitude and asking for interviews.

Once when he was told on such an occasion that he could not have an interview, he asked anxiously, "Does it mean that you will drop me as hopeless?" This patient, having a French name and speaking a little French, was approached sometimes in French. One day when coming out of coma he was greeted with "*Comment allez vous?*"* to which he answered after a short hesitation, "*Voulez vous coucher avec moi?*"* It was not a surprise to hear

*"How are you?" and, "Would you like to go to bed with me?"

such an overt homosexual advance, as his history was suggestive of such tendencies. In former interviews, the writer had often tried to discuss homosexuality, but there had been no response—only intensive blocking. After this occurrence, the patient was directly questioned about homosexuality. He denied ever having had homosexual relations, but spontaneously admitted he had never been sure of his manliness. He was seemingly glad to discuss this topic and showed much understanding and interest, but never responded on a subjective level. Nevertheless, he apparently was much relieved when he was assured that homosexuality is not a fate but a faulty habit. There was marked improvement in his condition after these interviews, and his restlessness on coming out of coma slowly faded away.

Case 3

K. G. R. is a 41-year-old divorced man, characteristically very accident prone during his whole life. There is a long history of a schizophrenic process; and he has been in and out of mental hospitals since 1939. He has been in Marcy State Hospital since 1949. He showed a mixture of catatonic and paranoid features: negativism, assaultiveness, grandiose ideas, ideas of reference, auditory and somatic hallucinations. During his previous hospitalization, he received ECT without any improvement; and he suffered a chipped fracture of a vertebral body. He was placed under insulin-coma treatment October 1951 as one of the chronic cases to be treated. At that time, he was more catatonic than paranoid, stiff, negativistic, refusing to co-operate and stating that his health depended on magnetism and that all his bones were broken. He would lie in bed with closed eyes, in a stiff position not moving for hours.

Before going into coma, he became restless, agitated, fighting with all his strength. When coming out of coma, he was friendly for a while, but soon relapsed to his former negativistic behavior. During the treatment, there was slow improvement insofar as he showed a little interest in his surroundings and became more co-operative for hospital routine. One day when coming out of coma, he was unusually restless, struggling with his feet in a state of acute anxiety, repeating imploringly, "Loosen my shoes, loosen my shoes!" He was in the usual chest and feet restraint. When his feet were freed, he smiled happily. As he had always been re-

strained in the same manner and had not complained previously, he was interviewed at once and gave the following story:

When a small boy, he had a pair of new shoes at Easter time. He had gone to church with his mother. The shoes were very tight and he "suffered terribly." He complained to his mother about this, but she would not listen and ordered him, scolding, to be quiet. He had agonizing pains until at last they arrived home. His feet were swollen and covered with blisters. His mother, who had been cross with him in church and on their way home, was very good to him when she saw his swollen feet. She put him to bed, gave him candy, and did everything to comfort him and to relieve his pain.

The day after telling this, his restlessness was less marked and he was surprisingly friendly and interested in other patients. He took part willingly in all activities. On another occasion, when he had a late reaction, he became very restless and excited. After giving him intravenous glucose solution, the writer spoke to him in a loud voice. He suddenly relaxed, smiled and said, "Are you here doctor? We could eat some spaghetti." When interviewed immediately and asked about the cause of his restlessness he said, "I thought I was in prison."

When questioned further about his fear of prison, he said that when he had had the pains in his feet, his mother threatened that, if he did not keep quiet, the police would take him to prison, and that later, at home, his mother gave him spaghetti. Since that time, he had always been afraid of being locked-in in a prison; and he does not believe that he deserves this. After this interview, his pre- and post-comatose anxiety disappeared gradually and his mental condition further improved.

In this connection, the writer would like to stress the fact that the anxiety and agitation had nothing to do with the restraint. In sanatorium practice, where patients usually are not restrained, and in late reactions, when patients are out of bed, one sees the same reactions. There are a number of patients who never show any anxiety or agitation.

Case 4

N. L. C. is a 29-year-old single man. The mother of this patient died in a mental hospital when the patient was very young. His father remarried and the patient was in a foster home for a long time. After school, he went to the CCC and shortly afterward, in

1940, he joined the army, receiving an honorable discharge in 1948. During his army service, he drank heavily and was hospitalized for the first time in a mental hospital with the diagnosis: inadequate personality, chronic alcoholism. Three more hospitalizations followed, and finally he was admitted to Marcy State Hospital in November 1950.

He was described as having a lot of self-confidence, "pep," being a hard worker, good-natured, having a winsome personality, and being a "little lamb when sober." When drunk, he threatened everyone who was near him. He was in numerous fights during his army service and afterward. At times, he had some kind of fainting spells with subsequent amnesia. He had a very active and promiscuous heterosexual life and a few homosexual relations.

During his previous hospitalizations, there were periods of hallucinations with vague ideas of reference and persecution. Prior to his admission to Marcy, he had a period of tenseness, depression and suspiciousness, complaining that people were talking about him, referring to his homosexual relations. One night, in a state of fear he went to the police station, and asked to be allowed to sleep there. During the night, he became extremely excited, screamed and shouted that there were people who wanted to shoot him, and that his father was hiding with a gun. From there, he was brought to the hospital. On admission, he showed the picture of acute catatonic excitement with auditory and somatic hallucinations, and a panicky state of fear of immediate death. After a few days, he became withdrawn and seclusive, and stared at the ceiling, motionless for hours. When asked what he was doing, he said that he was talking to God and that the Lord told him to call a priest. Later, he declared that he himself was God.

He was soon placed under insulin-coma treatment. During the pre- and post-comatose states, he was extremely agitated, as if fighting for his life. When out of coma, he was asked about the cause of his fears and he invariably said, "I must have had a bad dream." This extreme agitation recurred every treatment day until one day he had a late reaction. The writer was called and arrived just before the onset of the coma. He was still able to respond but was extremely restless. A small amount of sugar solution was given to keep him awake and he was immediately interviewed. He told the following story:

Every time he felt the weakening action of insulin a terrifying experience came into his mind. His mother was "taken away" when he was about two years old, and he was placed in a foster home until he was six. When he came home, he stole a dollar from his older brother and was soon caught. His brother took him down to the cellar, tied him down and let him lie there for three days without food or drink. Since that time, he has always feared being strangled.

An adequate amount of sugar was given, and this experience was thoroughly discussed. During the following treatments, there was only moderate restlessness, which slowly faded away completely. His condition improved slowly prior to this interview, but afterward the treatment could soon be terminated. After many months, this patient is still in fairly good condition.

* * *

These sketchy case histories are intended only to serve the purpose of giving a general idea of individual cases and to show the material offered during the pre- and post-comatose states. The interviews are merely mentioned without entering into details of further material revealed. Interpretations were given to the patients only with the material spontaneously offered and usually using their own words.

Considering the cases described, one sees that in two instances the patients remembered, or—to put it more cautiously—spoke about, only during the pre- and post-comatose clouded states, important childhood experiences they never mentioned before. In a third case, the patient seemingly realized the formerly denied cause of her troubles; and in a fourth case, latent homosexual wishes became evident. In all these cases, the uncovering, bringing into consciousness and discussion, of these highly emotional memories and self-deceptions caused a considerable diminution of tension and apparent relaxation of the patients. It was, perhaps, nothing more than the well-known process of catharsis, but, without the insulin coma, there were no means to uncover this hidden source of psychotic mechanism.

How insulin coma accomplishes the releasing of repressed memories and how it unmasks self-deceptions we do not know; but we do know that insulin oxidizes the glucose of the blood and thus removes the most important, if not the only, source of energy nec-

essary for the function of the brain. We know that the phylogenetically and ontogenetically youngest organs and tissues are the most sensitive to any change, and are so to anoxia. We know that, in organic lesions of the brain, recently acquired engrams vanish first. Thus one may presume that the frontal lobe, or wherever our highest mentations occur, is the first cerebral site to suffer from anoxia and is the last to recover. This hypothesis would explain the well-known fact that chronic cases respond much less than new cases to insulin-coma treatment, very likely because of the widespread association and organization of their psychotic mentation.

The neurotic and psychotic security and defense mechanisms are undoubtedly highly specialized and late acquisitions, so we again may presume that these functions are the first to be damaged and need the longest time to recover. It seems that, during the time of transition to unconsciousness and during the period from coma to consciousness, there is a temporary weakening, a breach, in the psychotic construction. The greater damage set would explain the greater productivity of unconscious material during the post-comatose state than during the pre-comatose, and that would explain the fact, too, that after a one-and-a-half-hour coma there is a greater productivity of such material than after only a one-hour coma. This could account for the disappearance often observed, of psychotic behavior during this post-comatose period and, inversely, for the appearance of hallucinations and other psychotic symptoms—in the second instance through weakening the conscious control. Dissimulating paranoid patients often produce their delusions during the post-coma state. The clinical improvement usually goes hand in hand with the alleviation of the pre- and post-comatose disturbances.

It seems that this specific action of insulin coma on the higher centers is the reason why insulin coma has hardly any effect in emotional psychoses, as in manic-depressive psychoses, depressions and catatonias. But in catatonics, after relieving the emotional tension by metrazol-convulsions or by combination of metrazol and insulin coma, the schizophrenic ideation can be modified. That would explain the well-known fact that insulin coma gives the best results in paranoid cases.

Against this theory it can be rightly objected that in many cases such relevant productions are not observed, or are neglected and

never discussed, and that the treatment still gives the usual beneficial effect. That is correct, but in observing improvement in the patients' condition during treatment, it is seen that gradual or abrupt change in behavior is usually accompanied by characteristic emotional reactions. These reactions are sometimes concealed with a smile by an otherwise sulky and depressed patient; or by an, "I am fine," answer to "How are you?" instead of the usual, "I am sick." Or a patient who, when waking up has invariably called for the nurse with a, "Mrs. Jones, let me up," one day calls another name. Or another patient who usually has been silly and manneristic when coming out of coma is suddenly well-composed. If we insist on questioning the patients about the cause of these changes we very often succeed in getting an explanation which suggests that their pathological ideations are somewhat altered.

One hears, for instance, a weeping patient answer the inquiry about the cause of her crying with, "I am awful homesick"—this from a paranoid patient who has accused her relatives and neighbors of making her home life unbearable. Another may ask, "When will I see my husband?" after having accused her husband of infidelity and cruelty, and having refused to speak to him on visiting days. Another may smile and upon questioning may answer, "I am so happy, I am pregnant." This patient has never had a child and has refused intercourse for fear of becoming pregnant. Similar occurrences are observed daily, but even if one does not follow and does not discuss them with the patients, the writer does not doubt they have some cathartic influences in allowing wishes and desires which were formerly repressed and hidden behind the psychotic construction to rise to the surface. If one enters actively into helping paients follow such impulses and ideas as are normal, this certainly assists them in removing or abandoning their pathological ideation.

Psychotherapists with orthodox analytical orientation will certainly find this technic very superficial and inadequate for analytical interpretation. The writer is well aware of the limitations of this procedure, but in a state hospital setting, even with very co-operative patients, it would be impossible to provide the time necessary for thorough analysis. All the patients mentioned are serious cases of dementia præcox, and one must be satisfied to get a modest glimpse into the pathological mechanisms. The material

gained must be used very carefully unless one wants to risk serious exacerbations, as often happen when deep-seated pathoplastic factors are touched.

Freudian psychopathology discovered that early childhood experiences are the roots of later neurotic or psychotic reactions. Conducting a psychoanalysis, one invariably meets them, but, before reaching them, invariably meets a great number of later conflicting experiences with similar emotional accent. By uncovering such experiences, we usually eliminate a barrier which liberates further repressed memories and, in the meantime, alleviates tension and anxiety. Considering these well-known facts, which are admitted even by the most conservative psychoanalyst, one should pay more attention to, and assign greater significance to, later experiences. There is no doubt about the pathogenic factors of early childhood experiences, but their importance is mainly in preparing or sensitizing the mental terrain for inadequate handling of adult experiences. The latter experiences, affecting vulnerable or sensitized persons, may cause or precipitate mental reactions known as psychonurosis or psychosis.

The perfectionist attitude of conservative psychoanalysts somewhat belittles these later experiences, demanding thorough analysis, a going to the roots. Of course that should be the ideal aim and procedure; but, and there are many buts, in most cases of neuroses and psychoses there are several reasons why thorough analyses cannot be carried out. Should we then, just because we are not able to offer patients "ideal treatment" abandon them to their suffering, or should we look for an available treatment—even if not perfect—that helps the patient to assume his pre-morbid life?

It is not the scope of this presentation to discuss these problems, but the writer thinks it necessary to point to the paralyzing and discouraging effects of such a conservative, but impracticable attitude, and necessary to try to justify short-psychotherapeutic measures. The "deep analytical" results in schizophrenia are not very encouraging; for example, Rosen's surprising results are criticized from authoritative quarters. The writer himself, after a long psychoanalytic and psychotherapeutic practice, is very doubtful whether psychoanalytic treatment of schizophrenics is at all possible, and if it is, whether it is not more harmful than beneficial.

The very poor ego organization of the schizophrenic is well known. This weak ego organization induces him to take the so-called schizoid attitude toward the outer world. This attitude protects him from frustrations which would result from his poor social adaptability. The schizoid character is a useful defense mechanism. As long as there are no stronger needs to break down the self-imposed limitations and barriers, or as long as the barriers are strong enough to withstand outer pressure, there is a weak but successful balance. If this balance is disturbed by whatever cause, schizophrenic disorganization follows. If one is able to channelize the schizophrenic's needs into, for him, acceptable expressions, or if one can enable him to evade greater pressure, it is possible to restore his pre-psychotic personality, and, with that, we have to be satisfied as long as we have no means for changing his personality. Lobotomy can be considered only as an ultimate sedative measure.

The writer is far from advocating the specificity of insulin-coma treatment of schizophrenia. As long as we do not know anything about the cause and nature of the schizophrenic process, and as long as we use the diagnosis of schizophrenia for psychopathologically dissimilar and etiologically unknown psychoses, there can be no discussion about specific treatment. But it can be said that at the present time insulin-coma treatment promises the best results, especially in the paranoid form of the disorder. The proper technical application and the establishment of an "accepting" environment are basic requirements. The creation of an atmosphere of friendliness, helpfulness and mutual understanding will help to reduce the genuine suspicion of schizophrenic patients; it will assist them in regaining their lost trust in human kindness which is essential to protect their sensitive egos. Systematic group-psychotherapy develops their ability for better interpersonal relationship and empathy.

The psychotherapeutic approach described here is a further tool in our hands offered by the insulin-coma treatment. If fully utilized, the writer believes, it will reward us with better and more durable results. Of course, one must keep one's distance from the organistic, "push button" orientation, and stop paying lip service to, while actually neglecting, the dynamic approach. Even if one believes in a primary organic basis of the schizophrenic process, for which, in fact, there is, as yet, no proof; the double, psychosomatic, determination of morbidity in general is today well-estab-

lished common knowledge, successfully applied in all fields of medicine. Naturally there is need for more psychotherapeutic training, more ability in observation, and additional time for the routine insulin-coma treatment. As long as we are satisfied with giving a patient a so-called "course" of ECT and later on a "course" of insulin-coma treatment—and then believe that we did everything possible and blame inadequate methods for our failures—we neglect and betray the most important psychiatric therapeutic procedure, which is psychotherapy. More optimism and enthusiasm, less fatalism and resignation reflected in our approaches, are the first, and may be the most important, steps to gain the much-needed confidence of the frustrated patient.

The writer has presented some observations during the pre- and post-comatose periods of insulin-coma treatment of schizophrenics. He has tried to show that the peculiarities of behavior and the occasional verbal productivities of the patients allow a glimpse into the dynamics of the psychosis and offer a key to a psychotherapeutic approach. The writer believes that these possibilities, fully utilized, may considerably deepen our understanding of the psychic mechanism of schizophrenia and in the meantime better our therapeutic results.

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FOLIE À TROIS*

A Case Report

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The concept of transmitted psychosis, induced "insanity," or psychosis of association, is well known and sufficient evidence has been collected to establish the phenomenon as a clearly defined psychiatric entity. In his review of 103 cases, Gralnick[1] postulated certain requisites for diagnosis and formulated the dynamics of the illness, while adding appreciably to the number of reported cases of *folie à deux*. Since 1900, however, there have been only six reports of *folie à trois* appearing in the American literature and even fewer reports of transmitted psychoses involving more than three persons. Kallmann and Mickey[2] discuss a case of *folie à sept* and one of *folie à neuf;* but, since they do not present the degree of association among the patients and since, in some cases, the family members involved were widely separated for many years prior to the onset of illness, it is felt that their cases do not represent induced or transmitted psychoses. These authors suggest that the term should not be applied to patients having blood relationship although the latter is held by some to be prerequisite to the observance of the phenomenon. The case reported by Kesselman[3] involves a mother, her daughter and son-in-law, and that reported by Kepner[4] concerns two sisters and a brother.

It is felt that the following represents a case of *folie à trois* occurring in siblings, although from the family history one might consider it to be a case of *folie à cinq*. The patients observed were: George, 58, and his two sisters, Anna and Mamie, aged 53 and 49 respectively. They were admitted to Pilgrim State Hospital, West Brentwood, N. Y., as a family unit on November 13, 1951, having been referred for care and treatment by the Welfare Department of New York City. The case material was obtained from the patients and substantiated as far as possible by social service investigation. The patients were interviewed separately and gave almost identical data.

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Family and Personal Histories

The patients' mother was born in Italy and was separated from her family at an early age, to live and be educated in a convent school. Upon completing her studies at the age of 16, she was restrained by family pressure from entering the convent as a postulant. Some time later, following a clandestine courtship, she was prevented by her parents from marrying a man of her own choosing. She was forced, instead, to marry the patients' father who had previously been selected by both his and the girl's parents.

The mother confided to her children the fact that no love existed between herself and her husband. In spite of this lack, however, and, evidently prompted by religious principles, there was never a separation, nor was there any overt domestic discord.

The patients describe their mother as a lovable woman, a good and righteous individual, over-religious and extremely demanding. She effectively controlled the family group by means of a "nervous illness." Mamie stated, "Mother had spells of nervousness and headaches." This was elaborated by Anna, who added that the episodes also included shaking, dancing and the singing of hymns. She was subject to frequent periods of depression, and sudden mood swings were not unusual. She was apparently overprotective and aggressive regarding her family, and the recollections of the patients indicate that they were not often permitted to leave her side. She sent them to school reluctantly, encouraging them to remain away, and tutored them privately. They were not permitted to play in the neighborhood because their mother felt that there would be arguments with others which would ultimately reflect on her. In view of her attitude, the patients remained at home constantly when not at school and, from early childhood, were trained in domestic activities. They speak tenderly of their mother, protest "undying love" for her memory, and insist that they neither showed nor felt any hostility toward her, in spite of what was then recognized by them as an unusual home situation.

The father of the patients was a cabinetmaker, whose only avocation was playing the clarinet. The patients extol his virtues and comment enthusiastically when discussing the attention he supposedly lavished on the entire family. The mother's nervous attacks upset the father considerably and caused him a great deal of worry. He used her illness in an effort to dominate the children, frequently pointing out the necessity of their being good children

so that "mother would not have a spell." He "had no friends" and followed a rather rigid routine of daily activity during which he avoided contact with others as far as possible. He spent his free time with the children, either at home or, occasionally, in a nearby park. He was not over-religious but was a good church member. The patients deny ever having been afraid of their father, although they readily agree that he was strict, and they took great pains to be sure that things were always as he would want them.

The mother died in 1920, the cause not known, and, after four years of steady decline, the father died of a cerebral vascular accident.

The family consisted of seven siblings, five of whom were born prior to the parents' migration to this country. The first two children died in infancy and the third child died at the age of six. The causes of these deaths are not known. The fourth child, Anthony, was a mental defective who was cared for by the patients and who died in 1946, also of unknown causes. The last three of the group are George, Anna and Mamie, the patients. Throughout their entire association, there is no evidence of overt hostility among them, and the children were uniformly devoted to the wishes of their parents. The patients mention some resentment at being kept apart from other children, but their reaction to this is crystallized by Mamie in stating: "We were trained from early life to understand that we were different from other people. We didn't have any choice about living the way we did and I'm sure that we never really disliked it."

George started parochial school at the age of six, and, although he was not considered a good student, he never had to repeat a class. He was fairly interested in academic pursuits and at one time aspired to practise medicine. Because of economic circumstances and the presence of psychosis, however, he relinquished this idea and left school after completing the primary grades.

Anna, because she was the older of the daughters, was entrusted with household duties at an earlier age than her sister. One of her principal duties was the care of her mother during the latter's "nervous spells." For this reason, she did not begin school until the age of eight, and at that time was extremely reluctant to leave her mother in order to attend classes. She was not interested in anything taught her at school and preferred her mother's private tutoring.

Having finished six grades of school at the age of 14, Anna applied for permission to work and discontinued her education. She had become interested in needlework and had also expressed a desire to become a cloistered nun. Because of her mother's constant repetition of the injunction that Anna must never leave home, she gave up the idea of religious life and became a dressmaker. She revealed that, during her formative years, she was frequently requested to join her schoolmates in social and athletic activities but, because she was never permitted to do so, she was later rejected by the group.

Mamie's education was perhaps more traumatic. She began school at the age of six, attending the same parochial school as her elder siblings. In the second grade however, she had considerable difficulty with the nuns in charge, was said to have been frequently disobedient and, on one occasion, was struck by one of the teachers. In spite of her desire to leave, she remained at school, at the request of her parents, until the age of eight. At this time, she was transferred to a public school in the neighborhood and was dismayed at being put back two grades in the process. During her school years, Mamie complained frequently of earache which caused her to remain at home. She was disinterested in school and did not see the necessity of learning to read and write. In the second month of the seventh grade, she left school after having applied for permission to work.

While George was permitted to work away from home, this privilege was not extended to Mamie or Anna. Of the two, Anna was permitted to accompany her father daily to a factory where she obtained the necessary materials and patterns for herself and her sister. She then returned home in the company of her father; and the two girls engaged in dressmaking and embroidery, completing all the work at home under the supervision of their mother. Upon completing the work, Anna was escorted back to the factory by her father in order to turn in the finished products and obtain new materials. Their work was evidently satisfactory and they continued with steady employment until approximately 1946. Following the death of their parents, Anna was accompanied by George and the same working conditions were preserved.

There was obviously little opportunity for companionship and friendship. The children formed a closely-knit group and rejected all outside interference. They were able to tolerate each other

fairly well but were extremely self-conscious when in contact with anyone alien to the family group. They were exquisitely sensitive to criticism, felt "different" and apart from others their own age, and felt, realistically, that people in the neighborhood were talking about them. None of the family had any special social interests or hobbies and, in spite of their own recognition of their rather unusual place in society, the prevailing mood was one of happiness. Because their early training did not permit it, they did not later seek recreation or enjoy it when it came unsought. The only luxury permitted was a radio which was in constant use. None of the siblings was interested in the theater, and Mamie cannot recall ever having seen a talking picture.

No sexual instruction was given to any of the children; and at the time of admission to the hospital, both Anna and Mamie had only an incomplete and hazy idea of the biology of reproduction. Anna learned about menstruation from a schoolmate at the age of 10 and felt at the time that she was being drawn into a "dirty conversation." Menarche occurred at 12 and caused her to react in a hysterical fashion. When she sought her mother's help, she received no instruction other than that concerning personal hygiene. In discussing relationships with men other than her brother, Anna recalled having been attracted to only one male and hastily amended the memory with a denial of having ever entertained the thought of marriage. Mamie had no ideas on the subject of menstruation and, although she shared a bed with her sister, had never observed the phenomenon until, with the onset of her own menses at the age of 12, she, too, cried and became hysterical. She felt that she was going to die, and turned to her mother but received neither instruction nor support. In relating these facts, Mamie stated, "You see, we were all bashful people in our house. We never kissed like other people and I don't think I ever heard the word sex except maybe once or twice."

Both sisters refused to undergo gynecological examination at the hospital and consciously related their refusal to the fear of pregnancy. When informed of this, George became quite concerned and argued with his own physician that the virginity of his sisters must be protected. George had a limited knowledge of sexual matters through his contacts with work associaties. He planned at one time to marry but, following the death of his par-

ents, felt it his duty to remain with his sisters in the capacity of provider and protector.

The patients are all members of the Roman Catholic Church and have been very attentive to religious activities. Throughout childhood and during most of their adult life, George and Anna have attended daily mass. Mamie discontinued the practice in later years because she was ordered to do so by an hallucination. She was permitted to attend church on Sunday but only in the company of her elder sister.

Psychosis

It is impossible to date the onset of psychosis individually or collectively, but an attempt has been made to treat the development of symptoms chronologically.

George was the first of the family to experience hallucinations, which have been restricted almost exclusively to the visual sphere. In 1900, at the age of eight, George frequently saw "beautiful musicians" whom he characterized as angels. They played only stringed instruments, but the music was never audible. In addition to his orchestral hallucination, George was frequently able to see the Pope who invariably bestowed upon him the apostolic benediction. When he reported these experiences to his parents, he was told that he should consider himself an extremely privileged and singularly honored individual to be able to see the Pope, and was encouraged in his personal sanctification so that he might later have visual communication with the saints as well. The frequency of his experiences is not known, but it has been firmly established that the phenomenon made George an important member of the family constellation.

Approximately two years after George's initial experience, Anna was attending her mother during a "nervous episode," and prayed to St. Anthony that her mother might be cured. She reports that she "sensed a stillness and saw St. Anthony filling a corncob pipe." The patient half-humorously added that she was shocked at seeing a saint smoke. She reports further that she asked the saint to help her mother and that he did not speak but nodded and disappeared. She revealed this experience to her mother and, quoting the latter's reply, stated, "It is because you are very pious. Shut yourself up to pray." None of the family members was disturbed by these experiences, and both parents were apparently

pleased at their gifted children. Anna considered this an unusual experience and George felt some annoyance at the challenge to his unique position in the family group. Soon after Anna started to hallucinate, and possibly stimulated by competition, George showed an almost pathological interest in the occult. He read many books on hypnotism and spiritism, and, attracted by the potentialities of telepathy, undertook many private experiments in an effort to communicate with others, both living and dead. He was universally unsuccessful in these attempts but frequently regaled his sisters with accounts of the world beyond and the possibility of contact with spirits. Anna remained non-committal, and Mamie openly scoffed during these recitations.

Following the death of the patients' father in 1924, all three were simultaneously startled by a knocking sound emanating from a closet in their home. The sound continued even after thorough investigation revealed no apparent cause and after all the neighbors had been interrogated. Having discussed the matter among themselves, the group decided to accept this as a communication from their dead father. In spite of his reading, George became terrified at this experience and insisted that they live with an aunt for a two-week period. When the experience was repeated, following their return to their own apartment, George, then the nominal head of the family, was pressed for further explanation. He revealed that prior to his father's death, the latter had indicated that their apartment should be vacated within a month after his demise. It was conveniently noted that the end of the first month after this event was rapidly approaching, and the family relocated in new quarters.

George had apparently been free of hallucinations at this point, but Anna's ability to see visions of the saints and "golden angels" was increased to the point of daily visitation She was never conscious of an auditory component to the hallucinations. Although Mamie had no experiences of her own to relate, she never doubted the validity of those described by George and Anna.

There is little available information concerning the family during the next 20 years. All three continued to work, Anna and Mamie at embroidery and dressmaking, and apparently made a fair economic adjustment. There was no outside interference, and the patients continued to function within the framework of their own seclusive society. Anna had attained dominance in the group,

since George claimed only infrequent audience with the Pope. On January 12, 1945, a date well marked in her memory, Mamie had her first hallucinatory experience which, unlike those of her siblings, was entirely an auditory phenomenon. She heard a voice which she was unable to identify and which directed her to discontinue the practice of sleeping with Anna. Her announcement of this directive provoked passive hostility on the part of Anna and frank admiration from George.

George reacted with envy at a later time however, based on the premise that his investigation and study best qualified him to be the subject of an auditory hallucination. It must be noted that, after Mamie had remained in the background for 20 years, her ability to hear voices gave her considerable status in the group and had an appreciable impact on the family equilibrium. Soon after her initial experience, she began to control the activities of the entire family by means of her hallucinatory directives. She was not usually permitted to transmit messages directly but did so by means of a ouija board which is still used occasionally in the family circle. On special occasions, the family would convene at early hours of the morning and faithfully transcribe the messages which were related by Mamie. In a series of directives which were obviously wish-fulfilling, it became apparent that Mamie would be married; the family would be elevated to an exalted position in the neighborhood; within a year they were to enjoy considerable wealth; the family dog was henceforth to be treated as an angel; George was to discontinue working on February 1, 1946.

During the inevitable testing operations on the part of George and Anna, it soon became apparent that if the messages received by Mamie were not acted upon, various members of the family would be stricken with paralysis. After several unpleasant experiences of this kind, there was little disobedience.

February 1946 marked the death of Anthony. Up to this point, little has been mentioned of the eldest sibling who had continued to live in the family group and was cared for by the others. As far as can be ascertained, he was a mental defective who could not speak and who had inadequate control of his muscles. He was treated with a great deal of respect by his brother and sisters and it can be inferred from their statements concerning him that they considered his defective state to be of significant divine origin. Anthony's illness began in 1945 and, because Mamie had received

instructions to the contrary, no physician was summoned. This culminated in the first episode of overt disagreement in the entire family history. George and Anna became very disturbed over Anthony's downhill course and, in direct contradiction of Mamie's orders, called a physician. Because of this contradiction and in keeping with another of Mamie's predictions, Anna became violently ill, and it was felt that the group was being punished for disobedience.

It was decided, therefore, that, although prescriptions had already been obtained, the medicine should not be administered to Anthony. As a result of this neglect, he died on February 1, 1946 of unknown causes. This date, it will be remembered, was previously marked as the last on which George should be gainfully employed. A considerable part of the family resources was spent on Anthony's funeral for which two complete sets of clothing, including overcoats, were purchased for him and buried with him. Following the funeral, George remained away from work for two weeks, which was felt to be a suitable period of mourning. He was told upon his return however that, because of his unexplained absence, his place had been filled, and his services were no longer required. George subsequently requested assistance from the New York City Welfare Department.

Within a period of six months, Mamie had received further directions to the effect that both she and Anna must give up embroidery and dressmaking, and both entered their names on the relief roll. She was also instructed not to appear alone in public and never again left the house. The family unit, now reduced to three in number, reached another equilibrium between 1946 and 1951, although it is felt that there was growing hostility on the part of George and Anna who were now completely dominated by Mamie's auditory hallucinations.

Mamie finally was requested by her siblings to consult a physician. In preparing for this, during one of her early morning conferences with the family, Mamie indicated that the consulting physician would probably recommend psychiatric treatment, which suggestion was to be ignored; and she reminded the group of the penalty for disobedience. When the doctor did, in actuality, recommend shock treatment for Mamie, her status was further augmented and she was now considered by the family to be a prophetess. It was felt that the expense of private treatment could not

be tolerated and Mamie received no electric convulsive therapy. Shortly after the suggestion was made however, she began to exprience a feeling, not unlike electricity, which began in the genital region and spread to various parts of her body. In describing the treatments, Mamie stated: "I would lie on the bed, face down, and see a likeness of the doctor with his hands moving all the time. After a little while, I would feel a strange thing in the place down here [indicating by gesture the genital area]."

These "treatments" continued for some time, and Mamie's power as the directing force of the family also increased. Various household duties were now delegated to other members until, ultimately, Mamie's sole function was to receive and transmit directions while George and Anna ministered to her.

During the ensuing years, the delusions and hallucinations became more bizarre and embraced every aspect of the family life. On one occasion they were told to prepare dinner for nine people; and, when the preparations were completed, Mamie ordered that everything connected with the proposed meal, including the utensils used getting it ready, was to be destroyed. These instructions were accurately followed, and, because of an absence of cooking utensils, the family went without food for three days. Mamie then supervised the preparation of a feast, following which rigid dietary regulations were observed.

In accordance with one of her earliest messages, Mamie selected as her prospective partner in marriage a dentist who had treated her 15 years earlier. She began a correspondence with him and observed an elaborate ritual in writing the letters. The notes were written and signed in Mamie's own blood after George and Anna had incised her finger and a special pen had been purchased. The letters were mailed at 3 o'clock in the morning from the post office at Pennsylvania Station.

There are a host of similar experiences which cannot be presented here. Although attention has been focused on Mamie as the dominant figure, it should be remembered that, during this entire interval, Anna continued to be visited by the saints, and George continued to have occasional visits from the Pope. The events leading to the patients' hospitalization took place early in 1951. George was again obtaining prominence by more frequent hallucinatory audiences and was the envy of his sisters as the frequent recipient of the papal benediction. Anna maintained her

status and Mamie was apparently less powerful in the family constellation.

The doctrine of reincarnation was then introduced by Mamie through the medium of her hallucinations and seized as the explanation for many of their previous experiences. The physician who had recommended shock treatments for Mamie was revealed to be the patients' father reincarnate. The social worker assigned to the case by the Welware Department was identified as a half-brother, born of the union of the patients' mother and her first lover whom she had been forbidden to marry. Anthony was reincarnated in various forms, as a golden angel, as the family pet, but more frequently as the doctor sent by the Welfare Department. Because of constant misidentification of persons and the destruction of household property, the family became a problem to the welfare authorities as a result of which the patients were referred to Bellevue Hospital for observation.

At Pilgrim State Hospital, the patients were always extremely co-operative, pleasant and agreeable. The two sisters were inseparable and none of the group was overconcerned about being hospitalized. Various members of the hospital personnel were identified as reincarnated relatives and were incorporated into the patients' system of delusions. Their course at the hospital was initially uneventful until they were transferred from the admission buildings. An effort was made to keep the unit together, but, once separated, George preferred to remain as far away from the building in which his sisters lived as the hospital grounds would permit. He gave no reason for this other than the fact that he was enjoying his work in caring for other patients on his ward. Psychological tests revealed all three patients to be of average intellectual endowment; observation indicated a diagnosis of dementia præcox, paranoid type in each case.

Conclusons

In evaluating the foregoing material dynamically, it is felt that the case represents an example of sustained sibling rivalry and the acting out of repressed hostility. It is apparent from the information given, that the mother had been descriptively psychotic and, possibly in his attempt to please her, George became the first of the family to experience hallucinations of a religious nature. Anna apparently lost favor until she, at a later time, also developed

an hallucinatory system. Underlying this, one sees the competition which must necessarily have existed among the family members. It is felt that Mamie acted out her hostility and, after a 20-year latent period, saisfied her competitive needs by emerging as the dominant member of the family unit. It is of further interest to note that in the acting out process, she ultimately became the exalted member whose personal needs were attended to by the siblings virtually reduced to slavery.

In spite of conscious denial, the resentment harbored by the patients toward their mentally defective brother is clearly shown by the neglect which resulted in his death. The attendant guilt was expiated first by the elaborate funeral arrangements and much later by his reincarnation as a physician.

The father's reincarnation as a physician who, in a delusional sense, treated Mamie, satisfied the need to elevate the father; and the sexual connotation attendant upon this aspect of Mamie's illness is apparent. The wish-fulfilling character of these reincarnations is of interest, especially when one considers that the patients' mother was never so honored.

Once established, the reciprocal delusional experiences of the three patients involved reached several equilibria, with each becoming alternately a dominant figure, ultimately to give way to another. Once the equilibrium was destroyed by hospitalization, George was apparently relieved to be free of Mamie's dominance and of the need to protect his sisters whose care was now insured.

Summary

Since 1900, only six cases of *folie à trois* have appeared in the American literature. In these, as well as in numerous reports of *folie à deux,* the factors of close association, relationship, and chronology of symptom formation have been stressed.

A case of *folie à trois* involving a brother and two sisters, in which the duration of illness is almost 50 years, has been presented for consideration.

The principal mechanisms involved in this case are considered to be sustained sibling rivalry and the acting out of repressed hostility.

Pilgrim State Hospital
West Brentwood, N. Y.
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OBSERVATIONS ON 36 PATIENTS WITH GENERAL PARESIS TREATED WITH PENICILLIN-MALARIA AND PENICILLIN ALONE

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The purpose of this paper is to report on treatment results, clinical and serologic, in a group of 36 patients with syphilitic meningo-encephalitis, treated with penicillin-malaria and penicillin alone. Various data of prognostic importance will be presented. Observations on the three aspects under which the disease manifests itself—psychiatric; physical, especially neurologic; and serologic—will be discussed separately and supplemented by brief references to the literature.

From more recent publications it appears that with the increase of time for observation the controversy over penicillin alone as against penicillin-malaria in the treatment of neurosyphilis has lost some of its vigor. While most papers of the years 1948 and 1949 stressed the superiority of combined treatment (Rose,[1] Curtis et al.,[2] Goldman,[3] Watson,[4] Kierland and O'Leary,[5] Spiller and Stewart,[6]) other authors (Dattner-Thomas,[7] Stokes and Gammon,[8] Parkhurst and Bowman,[9] Weickart,[10]) had already reported at this time on highly satisfactory results with penicillin alone. Curtis has now revised his opinion.[11] In the years 1950 and 1951 only a few authors preferred the exclusive use of the combined treatment.

The present consensus may be summarized: Most authorities regard treatment with penicillin alone as sufficient; but in cases of severe paresis, and in cases of taboparesis and optic atrophy, combined treatment is still considered by many the treatment of choice.

Material and Choice of Treatment

The material reviewed comprises 36 patients treated with penicillin-malaria and penicillin alone in a 400-bed service which for many years has performed the treatment of all male cases of neurosyphilis admitted to Hudson River (N. Y.) State Hospital.

At the beginning of 1949, penicillin was added to all malaria treatments. From June 1950 on, penicillin alone was the only treatment used for new admissions. A few patients had already been treated with penicillin-malaria prior to 1949.

The series presented includes all new admissions from January 1949 until May 1951 and also five patients who previously had been treated in the hospital with malaria-penicillin.

Eighteen patients in the series were treated with penicillin-malaria and 18 with penicillin alone. The equal numbers of these two groups are merely coincidental.

The *date of infection* was known in 18 cases (50 per cent). The average interval which had elapsed from the time of infection until hospitalization amounted to 19.8 years for 16 of these patients. The remaining two patients suffered from congenital syphilis.

The *average age on admission* was 49.7 years for all cases together, 46.8 for the patients who showed improvement and 50.8 for those who remained unimproved.

The *average duration of symptoms until hospitalization* was 17.6 months for all patients, 9.1 months for the improved and 20.9 for the unimproved.

The *average duration of hospitalization* was 5.9 months for the 10 patients who improved and could be discharged and 30.9 months for the patients remaining in the hospital at the time of this writing (1952).

Methods of Treatment

Penicillin-malaria. A tertian malaria strain was used which was preserved in the service by inoculation from one patient to another. A few patients who did not take tertian malaria required inoculation with quartan strains which had to be obtained outside. Inoculation was routinely performed by intravenous injection of 4 to 8 cc. of blood. The difficulty in taking malaria in the Negro race was illustrated by one patient who required five inoculations and finally terminated it spontaneously after three chills. The goal was 50 hours or more of fever over 103°. This was reached by 11 patients only (61.1 per cent). The penicillin used in the combined treatment was aqueous penicillin started at the height of the first paroxysm and given every three hours in around-the-clock doses until a total of 8,000,000 units had been reached.

Penicillin alone. A brand of penicillin containing 300,000 units procaine penicillin and 100,000 units aqueous penicillin per cc. was given daily for 20 days up to a total of 8,000,000 units.

Complications

Among the 18 cases treated with malaria-penicillin, complications occurred in seven patients (38.8 per cent), necessitating termination in six cases (33.3 per cent).

Jaundice. Severe jaundice was observed in three patients after 54, 43, and 12 hours respectively of fever over 103°. Malaria had to be terminated in all three cases. A fourth patient became jaundiced five weeks following malaria therapy with 58 hours of fever. The icteric index in this case was greater than 100, and the cephalin-flocculation test 2 plus. Following treatment with low fat, high carbohydrate diet, liver extract, and vitamin B_1, the icterus subsided after three weeks duration.

Circulatory collapse, alarming enough to require immediate termination, was encountered in two cases.

Projectile vomiting and marked prostration after the first chill was the reason for discontinuation of malaria in the sixth patient.

No deaths occurred during or after malaria therapy.

No penicillin reactions were observed.

Results

In Tables 1 and 2 the clinical and serologic results in the penicillin-malaria and the penicillin-alone group are demonstrated.

Table 1. Clinical Results

Type of treatment	Much improved	Improved	Slightly improved	Unimproved	Deaths	Totals
Penicillin-malaria	7 (7 discharged)	4	3	3	1	18
Penicillin alone	2 (3 discharged)	3	6	4	3	18
Totals	9	7	9	7	4	36

From Table 1 it is evident that the clinical results in the cases treated with penicillin-malaria were better than those in the cases treated with penicillin alone. Satisfactory clinical results (much improved and improved) were achieved in 11 patients (61.1 per cent) treated with penicillin-malaria as compared with only five patients (27.7 per cent) treated with penicillin alone. From the former group, seven patients (38.8 per cent) were discharged, and from the latter group only three patients (16.6 per cent). There are, however, several factors which decrease the apparent significance of the superiority of combined treatment: (1) The number of cases is small; (2) the average age in the penicillin-malaria group happened to be lower than in the penicillin-alone group, and (3) the patients in the combined group were followed up longer,

as their treatment had been finished before June 1950, as was mentioned before.

In Table 2 are demonstrated the serologic results which were obtained between six months and three years after termination of treatment. These are based on the Dattner-Thomas formula of spinal fluid activity. The serologic findings other than cell count and protein will be presented later. In this table, "no activity" comprises a cell count up to 4 and protein up to 30 mg. per cent. "Little activity" was arbitrarily defined as a cell count up to 8 and protein up to 60 mg. per cent. The results can only be shown for 33 patients because one patient died before his spinal fluid control was due, and two of the discharged patients could not be followed up.

Table 2. Serologic Results (33 Cases)

Type of treatment	No activity	Little activity	Unchanged or increased activity	Totals
Penicillin-malaria	7	9	1	17
Penicillin alone	4	9	3	16
Totals	11	18	4	33

There is again evidence that penicillin-malaria was superior to penicillin alone. For the evaluation of the spinal fluid findings the same reservations are valid as have been made for the clinical results.

Observations and Comments on Psychiatric Aspects

It is well known that the clinical picture depends mainly on two factors which are also of major prognostic importance: (1) the degree of impairment of the intellectual functions, and (2) the type of psychosis.

Impairment of Intellectual Functions

The degree of impairment of intellectual functions is of the utmost importance since it reflects directly the extent of the structural cerebral changes. It is generally agreed upon that the less deterioration that is present before start of treatment, the better the prognosis.

In order to determine the severity of impairment of the intellectual functions on hospital admission, the mental status was sub-

jected to a detailed evaluation. The different degrees of intellectual impairment were designated as mild, moderate, and marked. Classifying the material according to these terms, significant differences were obtained in a comparison of the improved with the unimproved cases. *Mild* impairment was present in eight (50 per cent) of the improved and in only three (15 per cent) of the unimproved. *Moderate* impairment was present in six (37.5 per cent) of the improved cases, as compared with three (15 per cent) of the unimproved cases. *Marked* impairment was found in only two (12.5 per cent) of the improved, and in as many as 14 (70 per cent) of unimproved patients.

The method of utilizing the mental status for the evaluation of the intellectual functions is necessarily less exact than the application of psychological tests. Test methods have more recently been used by two authors (Goldman 1948,[3] and Sternberg 1950,[12]), both employing the Bellevue-Wechsler test.

Types of Psychosis and Correlation with Pre-Psychotic Personality

The official classification does not provide for any subgroups in psychoses with syphilitic meningo-encephalitis. For a more detailed study than this classification affords, subdivisions are, of course, essential. Kraepelin's well-known classification into four types (expansive, agitated, demented, and depressed) is still widely used. As regards the relation of psychosis to pre-morbid personality it has been for many years a matter of common knowledge that, apart from the intellectual deterioration, the type of pre-psychotic personality determines the type of psychosis. It is, however, not always observed that the normal personality develops a simple or dementing type of psychosis, the schizoid personality a schizophrenic-like psychosis, and so on. In the present material a direct correlation between pre-morbid personality and type of psychosis could sometimes not be established, and reference will be made to these situations in the discussion of the different subgroups.

In Tables 3 and 4 are demonstrated the distribution of pre-psychotic personality types and the types of psychosis.

The different psychotic types will now be elaborated upon in some detail.

Table 3

Pre-psychotic personality	
Apparently normal	20
Unstable	3
Schizoid	3
Psychopathic	2
Unknown	8
	36

Table 4

Type of psychosis	
Simple or dementing	12
Expansive	9
Agitated	2
Depressed	1
Circular	1
Schizophrenic-like	3
Unclassified	8
	36

1. *Simple or dementing types.* Under this heading are listed those patients who showed different degrees of intellectual impairment with or without emotional dulling but who did not display major mood swings or special trends. Only two (16.6 per cent) of 12 patients in this group improved.

2. *Expansive types.* The pre-morbid personality of the patients classified in this group was commonly described as outgoing. The terms expansive and manic are often used synonymously. "Expansive," however, is preferred for the series presented, all patients listed in this group having shown pronounced delusions of grandeur in addition to euphoria, elation, psychomotor hyperactivity and impairment of intellectual functions. Hypomanic or mild manic states resembling functional psychosis were not observed. Neither was there a patient with previous manic or depressive attacks where the paretic process could have precipitated an affective psychosis. The favorable prognosis in this psychotic type was reflected in the improvement of seven of the nine patients in this group. The two patients who did not improve became demented eventually.

3. *Depressed types.* Only two patients with prolonged episodes of depression were observed, one of the two being listed in the circular group. Both depressions lacked entirely the emphatic and spontaneous character seen in depressions with manic-depressive psychosis, the depression being dull, flat, and overshadowed by confusion and sensorial defects.

4. *Circular types.* One patient whose depressive episode was just referred to had on admission presented a full-fledged expansive picture. It was interesting to note that nothing in this patient's pre-morbid personality pointed to a cycloid or syntonic in-

dividual. A brother of this patient, cared for in the same service and also suffering from general paresis, had a definitely schizoid personality make-up.

5. *Agitated types.* This type—formerly called by some galloping paresis—has, in general consensus, a poor prognosis. One of the two patients in this group remained in a state of continuous hyperactivity, finally refused to eat, and died six weeks after admission in spite of intravenous fluid therapy. He had been treated with penicillin alone. The other patient, who showed a marked admixture of manic features—the pre-psychotic personality being of schizoid make-up—eventually improved.

6. *Schizophrenic-like types.* The schizophrenic-like types are of interest, not only from a psychopathologic, but also from a prognostic viewpoint. All authors agree that their prognosis is less favorable than that of other types. Kopp and Rose[13] found improvement in only 25 per cent of their schizophrenic-like cases as compared with 90 per cent of cases with manic-depressive symptomatology. Likewise Landau[14] reported improvement in only a fourth of his patients with schizophrenic-like symptoms while two-thirds of the demented group improved.

As evident from Table 4, the present material comprised three patients of the schizophrenic-like type. One improved, two remained unimproved. One of the two unimproved cases corresponded to what some authors have called paranoid-hallucinatory psychosis and attributed to the effect of treatment with arsenicals or malaria. This patient had, on admission, been markedly expansive; and it was not until a month after termination of malaria that he began to react to auditory hallucinations and to express many delusions of bodily influence which have persisted for several years until today. Dattner[15] summarized the theories offered on the pathogenesis of this syndrome as follows: Paretics are liable to develop this picture when there is (a) constitutional disposition or (b) depressed liver function caused by acute or chronic intoxication. The present patient neither had a constitutional pre-disposition—his pre-morbid personality being obviously outgoing—nor was there evidence of impaired liver function.

7. *Unclassified types.* In addition to the foregoing groups, there are cases which cannot be properly classified under any of the types just described. Of the eight patients listed under this heading, two showed mild intellectual changes only, three also dis-

played emotional instability, one showed mild paranoid ideas, and one had transitory visual and auditory hallucinations precipitated by alcohol. In the eighth case, an acute alcoholic hallucinosis was superimposed upon an asymptomatic paresis.

Observations and Comments on Physical (Especially Neurological) Aspects

General paresis and taboparesis. Of the 36 patients, 26 suffered with paresis and 10 with taboparesis. The proportions of these diseases were 13:3 in the improved, and 13:7 in the unimproved group, that is the taboparetics constituted only 23 per cent of the improved and 53.8 per cent of the unimproved patients. While there was no apparent difference in the psychoses of paretics and taboparetics, the neurologic manifestations of the tabetic patients were of comparatively mild character. With the exception of one patient whose lower extremities eventually became paralyzed and who died of intercurrent infection, none of the patients showed progression of symptoms. All nine were able to walk. No gastric crises were observed; lancinating pains were rarely complained of; and there was no patient with severe tabetic arthropathy.

Neurologic signs. The most common neurologic signs (paresis and taboparesis combined) were in order of frequency: Pupillary changes (Argyll-Robertson, fixed, or sluggish) in 28 patients (77.1 per cent), dysarthria in 24 patients (66.6 per cent), abnormal knee jerks in 22 patients (61.1 per cent), impaired gait in 19 patients (52.7 per cent), dysgraphy in 17 patients (47.2 per cent), abnormal ankle jerks in 17 patients (47.2 per cent), and positive Rombergs in 10 patients (27.7 per cent).

Little change of neurologic signs after treatment was observed with the exception of improvement of gait and co-ordination and occasionally very striking improvement of dysarthria.

Apoplectic and epileptic symptoms. In six patients the disease became manifest with cerebrovascular accidents resulting in hemiplegia and hemiparesis respectively. There was permanent hemiplegia in two cases, permanent hemiparesis in one case, and only minimal residuals in two patients. The sixth patient showed improvement of motor functions of the extremities, but his motor aphasia, agnosia, and apraxia persisted.

Convulsive seizures before admission, but not observed in the hospital, occurred in two patients. Three were admitted to general

hospitals for epileptic attacks and subsequently transferred to the state hospital. Two of these three patients were cases of juvenile paresis. Three other patients suffered seizures for the first time while in the hospital. Five patients had grand mal seizures only, one patient both grand and petit mal seizures. As a rule, the seizures responded to anticonvulsive medication, as well as other forms of symptomatic epilepsy do. Status epilepticus, however, occurred in two patients. It could not be controlled in one, who died of it. The second patient—almost moribund—could be saved.

Optic atrophy. There was one case with optic atrophy. The patient was treated with penicillin-malaria and progressed.

Deaths. The mortality rate was 11.1 per cent (four patients). In three patients, the cause of death was directly related to the paretic process. Mention has been made of these three cases elsewhere. The fourth patient died following a midthigh amputation for peripheral arteriosclerosis.

Combination of Paresis with Other Organic Diseases

Arteriosclerosis. Many patients were in the arteriosclerotic age group, and arteriosclerosis often contributed to neurologic and psychiatric signs. While the differentiation between syphilitic and arteriosclerotic heart disease was often difficult—heart disease was present in eight patients—it was in almost all cases impossible to evaluate the role played by associated cerebral arteriosclerosis.

Trauma. The influence of head trauma has occasionally to be appraised. In one patient, it was at least a contributory factor. This man—a truckdriver—was found below his truck in a convulsive state. During hospitalization he showed a right hemiplegia; and a skull x-ray revealed a fracture through the left os occipitale. It could not be ascertained in this case if the convulsions were caused by the head trauma or were preceded by it.

Alcoholism. Combinations of paresis with alcoholism have already been mentioned.

Observations and Comments on Serologic Aspects

The validity of the concept that the spinal fluid reflects accurately the state of the neurosyphilitic process is generally recognized. Most authors agree with Dattner-Thomas that cell count and protein are exact indicators of the activity of the syphilitic process and that indication for, and extent of, treatment depend

mainly on these two factors. It appears of interest to mention that the Dattner-Thomas concept has occasionally been disputed in the literature. Grover,[16] having examined 1,632 neurosyphilitic cases, concluded that the spinal fluid Wassermann is a more accurate index of parenchymal activity in paresis than cells and protein, and is a more accurate prognostic guide; while Goldman,[3] reviewing 140 cases, felt that cell count and protein are so susceptible to even the most inadequate treatment that they can hardly be used as a key to therapeutic results.

In this paper, the Dattner-Thomas concept has been adhered to.

In reviewing blood and spinal fluid findings, it was interesting to note that one month after termination of treatment the cell count had already returned to normal in four cases (two treated with penicillin-malaria and two with penicillin alone) and the protein had diminished more than 10 mg. per cent in 14 cases (seven treated with penicillin-malaria and seven with penicillin alone).

Cell count and protein values in 33 patients checked between six months and three years after termination of treatment have already been demonstrated under treatment results.

It remains to report on changes in blood and spinal fluid Wassermanns and in colloidal gold curves. Because of the limited time of observation, no marked changes in these values were to be expected.

The *blood Wassermann* became normal in no case. The titer decreased markedly in seven cases (four treated with penicillin-malaria and three with penicillin alone).

The *spinal fluid Wassermann* became normal in one case (treated with penicillin alone). The titer dropped from above 10 to below 10 in six cases (four penicillin-malaria, two penicillin alone).

Decrease in the *colloidal gold curve* occurred in five cases with initial D-curves, two changing to C-curves and three to B-curves. (Three of these patients were treated with penicillin-malaria, two with penicillin alone.) Reversal to normal curves occurred in no case.

Correlation of Serologic and Clinical Results

Serology and psychosis improved: 21 cases, slight clinical improvement included (12 penicillin-malaria, nine penicillin alone).

Serology and psychosis unimproved: three cases. Two patients died. (All were treated with penicillin alone.)

Serology unimproved but psychosis improved: one case (treated with penicillin alone). The serology remained unimproved in spite of re-treatment.

Serology improved but psychosis unimproved: eight cases (one died). (Three were treated with penicillin-malaria, five with penicillin alone.)

The last of the four possible combinations—serology improved but psychosis unimproved—is the most unsatisfactory one from a therapeutic viewpoint. Two explanations are possible: (1) The irreversible cerebral damage is too far advanced; (2) affective or trend-reactions may persist independently of the course of the neurosyphilitic process.

Most of the unimproved cases belonged to the first group.

There are, however, situations, where the lack of correlation between serologic and clinical findings is more complex. This series included three re-admissions, all three patients having been well-adjusted outside the hospital for more than two and one-half years. All three patients presented an acute paretic psychosis, the severity of which was not reflected in the spinal fluid findings which showed but little evidence of activity.

In such cases, which occur occasionally, one must rely on the clinical aspects alone in evaluation of the paretic process and, in closing, the writer would quote Rose, who, reviewing neurosyphilis in the *American Journal of Psychiatry*,[17] said: "We, as therapists, should not lose sight of the patient in our efforts to destroy the invading spirochete."

Summary and Conclusions

1. Of 36 patients with general paresis, 18 were treated with penicillin-malaria and 18 with penicillin alone.

2. Choice and methods of treatment, as well as complications, were described.

3. The prognosis in the series presented was found to depend mainly on (a) duration of symptoms, (b) degree of intellectual impairment, (c) type of psychosis, (d) combination with tabes, (e) age. These findings confirm often-reported observations by others.

4. Satisfactory clinical results (much improved and improved) were achieved in 61.1 per cent (11 patients) treated with penicillin-malaria and 27.7 per cent (five patients) treated with penicillin

alone. Satisfactory serologic results (available for 33 patients only) were obtained in 94.1 per cent (16 of 17 patients) in the combined group and in 81.2 per cent (13 of 16 patients) in the penicillin-alone group.

5. The clinical failure rate was 22.2 per cent (four patients) for the patients treated with penicillin-malaria and 38.8 per cent (seven patients) for the patients treated with penicillin alone; the serologic failure rate was 5.8 per cent (one of 17 patients) and 18.7 per cent (three of 16 patients) respectively.

6. Some superiority of the combined treatment remains even after allowance has been made for factors rendering the composition of the group treated with penicillin-malaria more favorable. Penicillin alone, however, outranks the combined treatment with regard to safety, lack of complications, and ease of administration.

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ON BRONCHIAL ASTHMA: A CASE REPORT

BY ALBERT E. SCHEFLEN, M. D.

Emotional disturbances in asthma have been reviewed and discussed by such authors as Alexander,[1] French and Alexander,[2] Dunbar,[3] and Weiss.[4] Weiss felt that the attack represented a suppressed cry for the mother. Alexander emphasized the "repressed dependency upon the mother," rejection or frustration, as a precipitating cause, and the termination of an attack with confession or crying. He pointed out the respiratory difficulties that may be seen when a child attempts to suppress crying.

Case Report

Mary was born in rural Delaware in 1904. Her father used alcohol excessively, and the mother had heart disease. Mary was the youngest of four children. One brother was seven, a sister five, and another brother three years older. The older boy had asthma. The older sister gradually assumed responsibility for the household and for Mary. The brothers have detached themselves from the family. The writer can give no objective portrait of these people. Mary alternately idealizes and berates them for their intolerance and rejection. To the sister, who is apparently identified with the mother, Mary is ambivalent and overdependent, and seems to have been for years.

Mary didn't like school. She "couldn't learn," made poor progress, and quit at the legal age. She felt rejected by her teachers and once transferred to parochial school to "get more attention from the teachers." As an adolescent she was evidently overmodest, passive, outgoing, unhappy, "easily upset, inclined to cry, sickly, and pampered." The mother died when Mary was 16. The sister assumed responsibility and Mary fell into conflict with her. She became sexually promiscuous and, on occasions, drank heavily. After a day's drinking, it is said that she was "sick for days." She once had a lover's name tattoed on her thigh and she feels this makes her unlovable. At 20 she had a hysterectomy, presumably because of pelvic inflammatory disease.

In Mary's early 20's, the sister married and left the house. The patient became the father's housekeeper. She did a very poor job —between wandering away, apathy, and parapractic behavior or errors in judgment. She developed "spells" of falling and thrash-

ing in a clear state of consciousness, and these still occur, predictably, when she is rejected. She became increasingly withdrawn, preoccupied, autistic, and inappropriate in affect.

At the age of 35, she was admitted to a colony for the feebleminded. Her Stanford Binet was 51; the Stanford Vocabulary 62, and the Army Performance Test 47. When "frustrated," she had a "spell," but she achieved a semi-employee status and commendably carried out her duties in the care of children. She was very dependent on the matron and untiring and solicitous to her small charges. At the age of 41, however, she developed the delusion that she had killed the superintendent. She became depressed, self-deprecatory, and agitated. She plucked out her eyebrows. She was transferred to Delaware State Hospital, Farnhurst, Del., in 1945. On arrival she was mute, stuporous, and incontinent. She exhibited waxy flexibility. In the next five years there were repeated catatonic episodes, which responded to electric shock. During remissions, she was childish, overdependent, and autistic, but, when praised, worked diligently in the ward kitchen as a waitress. Since 1951, no catatonic symptoms have been observed. She is still childish and autistic, and she exhibits swings from mild hypomania to mild depression. She visits her sister on week-ends. Every Monday, she decides the sister doesn't care for her and resolves never to go home again; and every Friday, she accuses the physician of disinterest and asks to be discharged.

For some 10 months, she became increasingly dependent upon the writer. She sought my attention in a hundred childish ways. She insisted upon having her room next to the therapy office, and she jealously watched each patient entering for interview. She fantasied that I kissed them. The slightest rejection resulted in a "thrashing spell," sulking or depression, anger displaced to another patient, or a host of somatic complaints. *Her dependency or transference, however, was more intense to my wife, whom she had never met.* Incessantly she extolled virtues she presumed my wife to have, remarked on the good fortune of my children in having such a mother, identified with them, and begged to be taken into the household—presumably as a maid.

In January 1952, Mary had coryza, and I expressed concern over a cough. She developed a "whoop" with laryngeal stridor. She produced it regularly and almost exclusively when I was with an-

other patient in the therapy office. One physician thought she might have whooping cough. On March 14, another patient began working at my home as a maid. During the lunch hour Mary heard this and realized, though I had repeatedly prepared her, that she was not to be "Mrs. Scheflen's maid." She looked for the other patient in order to attack her, then asked the nurse to allow them to be roommates. She complained bitterly to the attendants about my decision, then went to her room and went to bed. After lunch, I returned to my office and began a therapeutic session with another patient. There was a *loud crying, exactly typical of the hungry infant,* and I found it was coming from Mary's room. The nurse and three attendants later revealed that they had at first shared my belief that someone had smuggled an infant into the ward. When I entered the room, Mary stopped this crying and began deep inspiratory gasps with laryngeal stridor. She was thrashing about in one of the "spells" described previously. I firmly held her face and called her name. She replied, "I'm all right. Leave me alone. I'm just dreaming." I asked her what she was dreaming, but she refused to answer. I confronted her with the fact that she was feeling rejected. At this point, she began to have wheezing typical of bronchial asthma. She said, "No, I don't care." An attendant said, "Don't lie to the doctor, Mary, you do care."

Mary's *wheezing became violent. It was typically asthmatic.* I put my ear to her chest and heard classic sibilant rales. She managed to gasp out, "It's my sister. Last week-end she told me to stop laughing. She said I act like a child. She won't take me home if I act like that. I won't go home. I'll stay right here." At this point she began to sob and produced tears. The wheezing immediately stopped. It lasted the length of the verbatim quotations. Between sobs she said, "Let me up. I have work to do in the dining room." She broke away forcibly and ran out of the room.

In May, she learned I was leaving for another position. She begged me to "adopt" her and take her with us. When I tried to explain that I could not, she had another asthmatic attack and "thrashing spell." She denied previous attacks and no history of them could be obtained. Since I knew I was leaving I resisted the temptation to explore the personality and history in therapeutic sessions.

SUMMARY

The history of a patient of deficient intelligence who had had a catatonic type of schizophrenic breakdown is recorded. She was extremely dependent and had an intense transference to the physician and his wife. When rejected, she cried with expiratory screams exactly like an infant, and then had a classical attack of bronchial asthma. The asthma immediately disappeared when she began to sob and shed tears. During the attack, she blamed her sister for rejecting her. Later, in a similar situation, she had another attack.

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INVOLUTIONAL MELANCHOLIA

BY JOSEPH BARNETT, M. D., ARTHUR LEFFORD, M. A., AND DONALD PUSHMAN, M. D.

Since the first description of involutional melancholia by Kraepelin, the subject has continued to be in controversy. The description of this syndrome has been expanded and differentiated by numerous writers; its etiology attributed to a variety of factors and its psychopathology variously conjectured. The diversity of attitudes which prevail toward it is eloquently illustrated by a review of the literature.

In this paper, an attempt will be made to clarify and systematize the psychodynamics of the syndrome of involutional melancholia. The psychodynamics of depression, *per se,* have been described and elaborated by Freud,[1] Abraham,[2] and other psychoanalytic writers.[3, 4] Some of these writers have discussed and analyzed the dynamics of certain aspects of the involutional depression. Yet because of the heterogeneity of the group referred to clinically as the "involutional psychoses," dynamic understanding of this syndrome has remained obscure. The present discussion will be restricted to a discussion of the typical agitated depressions of this group. The pre-psychotic personality and precipitating factors will be related to the onset and symptomatology of the syndrome.

The classical psychoanalytic approach to depression has emphasized several important predisposing factors, namely: the presence of a strong oral dependent fixation in personality development, the loss of an external object, and the presence of a rigid and severe super-ego. The psychodynamics of depression are explained as due to a basically ambivalent relationship toward objects which supply narcissistic gratifications to the individual. With the threat of loss, or actual loss, of the object, the hostility of the ambivalent relationship is mobilized and directed against the object. However, since the object is no longer externally present, the hostility is directed against the introjected or incorporated representative of the object, this becoming one source of hostility directed against the self. Furthermore, the very expression of hostility in a personality with a severe and punitive super-ego results in considerable guilt, which in turn becomes another source of hostility directed against the self.

The Pre-Psychotic Personality in Agitated Depressions

Although analytic theory emphasizes the oral fixation of patients who are predisposed to depression, the writers were impressed by the large number of involutional melancholiacs who showed anal character traits on clinical examination and whose pre-psychotic personality was predominately anal. Prompted by this impression, the literature was reviewed. It was found that a number of references in the psychoanalytic literature indicate the findings of anal personality traits in depression. Abraham[2] first noted the obsessive-compulsive character formation in the free intervals of manic-depressive patients. Jelliffe and White[5] noted anal obsessive tendencies in involutional melancholiacs. Gero,[3] in an analysis of an obsessional neurotic, found that with the breakdown of the character defense the patient suffered a strong but temporary melancholic phase. Fenichel[4] states that involutional melancholia occurs in compulsive characters of an especially rigid nature.

Non-analytic authors have also stressed the importance of traits described as anal compulsive by the psychoanalysts. Brew[6] clearly indicated the rigidity and narrowness of adjustment of the pre-psychotic personality of these patients. Titley,[7] in a critical study, concluded that the general type of personality found to antedate involutional melancholia has been recognized by the analytic writers as the anal erotic personality. In another paper,[8] he describes a similar pre-psychotic personality in those patients classified as agitated depressions other than the involutional depressions. Palmer and Sherman,[9] in a broad and well-integrated study, stressed the anal pre-psychotic personality and attempted to relate it to the precipitating factors.

It would appear that the existence of anal character traits in the pre-psychotic personality of the involutional syndrome is a fact supported by the clinical findings of psychiatrists differing widely in theoretical orientation. It is felt therefore, that a more thorough understanding of the dynamics of the involutional melancholiac may be approached only through an understanding of the dynamics of this predisposing personality.

Description of the Anal Character

The anal character has been described by many analytic authors.[2, 4, 10] The major traits ascribed to this character are orderliness, frugality, and obstinacy. Frugality is a continuation of the

anal habit of retention. Orderliness is an elaboration of the obedience to, and the rebellion against the parental requirements covering the regulation of the excretory functions. Tidiness, punctuality, meticulousness, propriety, all signify a displacement of the compliance to the parental requirements in regard to defecation. The sublimation of retentive attitudes leads to parsimony, miserliness, collecting, and hoarding. The reaction formation to expulsive habits leads to cleanliness, orderliness, organization thoroughness, efficiency, purity, and aversion to contamination and soiling. Sublimations of expulsive habits lead to extreme generosity, extravagance, painting, sculpture and so on.

Analytic authors generally agree that the anal character has its roots in the attitudes developed around the conflicts engendered by toilet training. Rigid attempts at early toilet training are made by the parents—promising harshness and severity for disobedience, and love and narcissistic gratification for obedience. The child, caught between his developing anal erotism and his need for love and narcissistic supplies from the parents, resolves this conflict by the development of a forerunner of the super-ego, called by Ferenczi "sphincter morals," which is later replaced, when the introjected parental authority forms the super-ego.[4]

In the development of the anal character—because of the rigidity of the super-ego's defenses against the instinctual anal needs—certain habitual defensive ego attitudes have been established. Upon the maintenance of these ego attitudes the integrity of the personality depends. The super-ego is now the source of self-esteem and narcissistic gratification formerly supplied by parental figures. It will continue to supply these narcissistic needs as long as the individual continues to live up to its demands. It will withdraw narcissistic supplies when the personality fails to live up to its goals. Thus, the anal character's perception of failure to live up to the rigid goals of the super-ego would lead to a withdrawal of narcissistic supplies by the super-ego. Because of this constant threat, the anal character develops its characteristic rigidity and compulsivity, as described in the foregoing. It is necessary to recognize that the compulsive behavior of the anal character is actually an attempt to accede to the demands of the super-ego. The compulsions are a defense whose aim is to ward off the threat of punishment by, and loss of narcissistic supplies from, the

super-ego. To the anal character, compulsions are necessary to enable him to maintain self-esteem.

Decompensation of the Anal Character

In order to understand what leads to adaptive failure, consideration must be given to the specific compulsive behavior which has enabled the anal character to live up to his own super-ego demands. Such specific behavior patterns are as multitudinous as the diverse patterns of reaction seen in specific cases of involutional melancholia. It is possible to consider compulsive defense behavior broadly with respect to adjustments to work, interpersonal relationships, sexual adjustments, etc. In a given individual, there may be compulsive attitudes and needs with respect to any or all of these areas. Until the breakdown, the individual has been able successfully to live up to his super-ego's demands with respect to his needs in these areas. He has adapted at a specific compulsive level.

In the involutional period, readjustments become necessary. His character structure, however, demands that he act and behave in a manner no longer physically or socially possible for him. It is not the physiological or social changes *per se* that are crucial in the precipitation of the psychosis. It is rather the unique and personal significance, for the compulsive character, of these changes that precipitates the breakdown. The economy of the compulsive character is precarious. These changes imply his inability to continue his appeasement of the super-ego. Major environmental changes may occur to demonstrate to him his inability to continue his rigid adjustment. However, the unconscious perception of changes of a subtle nature may be the precipitating factor for the decompensation. Should the ego at any time perceive or interpret some event as an inability to appease the super-ego, the anticipatory anxiety of loss of self-esteem occurs to detonate the cycle of depression.

Although the involutional period introduces specific traumata which are of grave danger to the anal character, it is expected that depressive states corresponding to the involutional agitated depressions will be seen in anal personalities before the physiological involution as well as long after it. Thus the descriptive term "involutional" is misleading insofar as it implies a causal relationship between the clinical syndrome and physiological involution.

Psychopathology of the Agitated Depressions

The dynamics of the agitated depressions show a marked similarity to the typical dynamics of the reactive depressions. The differences in symptomatology reflect quite naturally the differences that do exist. The agitated depressions are superimposed on an anal character structure whose *raison d'être* has become the appeasement of a rigid, severe super-ego by compulsive character defenses. For this character type, narcissistic supplies are derived from the super-ego, but only as long as the defense mechanisms of the ego continue in the policy of appeasement. When environmental or physiological changes force the ego to perceive itself as unsuccessful in its habitual defense reactions, anxiety intervenes, the ego mechanisms are paralyzed and further prevent fulfillment of compulsive needs, and the depressive cycle begins. The anticipated and feared loss occurs—the super-ego withdraws narcissistic supplies and the hostility inherent in the ambivalent relationship which the ego has with the super-ego is mobilized and directed against the super-ego. Further hostility is directed against the ego.

One sees here the essential dynamic differences between the reactive depression and the agitated depression of the involutional period. The reactive depressive feels a loss of love from an object in the environment; the involutional melancholiac, the withdrawal of love from within the personality. A reactive depressive, as has been seen, directs hostility against a currently incorporated object; the involutional melancholiac against an object incorporated in early childhood. A trait of the anal character which leads to an important similarity in the dynamics is the ambivalence toward the super-ego. This ambivalence is reflected by the contradictory behavior so frequently seen in the compulsive character. It is apparent that in the involutional melancholiac, the super-ego is an ambivalent object, much as is the external object of the reactive depressive.

In both types of depression, there is a loss of narcissistic supply; in the agitated depression, from the super-ego; in the reactive depression, from the external object. Also, in both, depression *per se* is the result of hostility directed inwardly against two functions of the self, i. e., the ego and the super-ego. In the reactive depressions, hostility is directed against the currently incorporated object and against the ego, as the result of guilt over the expression

of hostility. In the agitated depressions, hostility is also directed against the incorporated object, the super-ego, which represents objects incorporated in early life. However, a greater proportion is directed against the ego, as a result of (1) guilt arising from the ego's failure to accede to the super-ego's demands, and (2) guilt over the expression of hostility. Thus, in the agitated depression more self-directed hostility is directed against the ego. The ego is overwhelmed by guilty self-condemnation, which becomes a more marked clinical feature in this type of depression.

Agitation, as an almost constant feature of this type of depression, may similarly be explained on the basis of these dynamics. The personality of the anal individual is such that equilibrium can be maintained as long as the compulsive defense system satisfactorily placates the super-ego. With the perception of failure, severe anticipatory anxiety occurs because of the certainty of loss of love and impending punishment by the super-ego. This anxiety is present both as free-floating anxiety, and as attempts at motor release of anxiety. This inability to bind anxiety for later release is a further manifestation of the limitation and regression of the ego in one of its major functions.

This anticipatory anxiety also accounts for the frequently expressed ideas of hopelessness and futility which appear in the agitated depressions. The overwhelming anxiety severely impairs ego functioning and, therefore, impairs attempts at adaptation. Thus the patient who states, "There is nothing that can be done, I am hopeless," is merely reporting his perception of his ego's incapacity to do anything about the situation.

The refusal of food seen in severe depressions has been clarified by Gero.[3] Food represents gratification of narcissistic needs, as well as hunger, therefore symbolizing self-esteem. Anorexia signifies the denial of love and esteem in severe self-recrimination and is a form of self-punishment.

In conclusion, it is seen that the clinical symptomatology of the agitated depression reflects the dynamics of the personality. From this point of view, the agitated depressions may be considered as the decompensation of the anal character.

Case Presentations

Although the clinical symptomatology and the pre-psychotic anal personality of involutional melancholiacs have been noted and

presented by other writers, two cases will be briefly presented to emphasize these features and to correlate the apparent precipitating factors with the dynamics of the personality. Both cases illustrate the decompensation of anal personalities when confronted with the impossibility of maintaining their rigid work patterns.

Case 1

G. J. was a 66-year-old male cabinetmaker, whose pre-psychotic personality was described as honest, sincere, truthful, thrifty, conservative, pessimistic, proud, strong-willed, stubborn, and with a set of high moral standards. He was considered an excellent cabinet maker—exacting, thorough, neat, punctual, impatient, rigid, and persistent in his work.

The onset of illness occurred about eight months prior to his mental hospital admission. At that time he had a heart attack for which he was hospitalized for two months. Following his return home and to work, he suffered another heart attack and was informed that he would be unable to resume his job. Almost immediately, he began to develop anxiety, lost his self-confidence, became seclusive, anorexic, and depressed. Agitation was a marked early feature. He was apathetic, expressed ideas of futility and hopelessness, stating that nothing could help him.

Case 2

M. C. was a 58-year-old married business man whose pre-psychotic personality was described as practical, parsimonious, overdemanding, domineering, persistent, obstinate, inconsiderate, unappreciative, and given to severe temper outbursts. He complied to the strictest letter of Hebrew orthodoxy. Occasionally, he was given to episodes of compulsive generosity, during which he would seek out strangers, buy them meals and provide them with accommodations. His hobby was modeling plastics.

During the two years prior to his mental hospital admission, his business suffered numerous setbacks. He gradually became restless and anxious and worried constantly about his finances. He became progressively depressed and agitated, paced the floor wringing his hands. He expressed ideas of futility and hopelessness, and stated that he was a failure. He insisted that there were discrepancies in his early income tax returns and feared that the authorities were going to punish him.

In both these cases, the anal pre-psychotic personality is unmistakable. In the first case, the precipitating factors involved a physical disability—two heart attacks—which precluded the maintenance of his rigid work adjustment. The patient showed anal character traits of an essentially retentive type which embraced many facets of his personality. His most persistent and marked compulsive system, however, appeared to involve his work situation, which was just the system where re-adaptation along less compulsive lines was indicated because of his heart attacks. Another interesting clinical observation is the appearance of impotence as a purely secondary symptom—apparently the result of withdrawal of libidinal cathexes seen so frequently in depression. In keeping with the dynamics, free-floating anxiety was seen to precede the early depressive elements. This is interpreted as anxiety over the impending loss of narcissistic supplies from the super-ego as a result of the perception of, in this case, an environmentally-produced prohibition preventing maintenance of compulsive defenses.

In the second case, one sees an anal character with an admixture of retentive and expulsive elements. An interesting example of ambivalence toward the super-ego is seen in a parsimonious, miserly individual who has outbursts of compulsive generosity. In this case, no physical precipitant is seen. Whether because of his own diminished productivity or because of economic conditions, he suffered business reverses. This was sufficient to demonstrate his inability to continue in his anal attitudes toward money, at once retentive and expulsive, and this precipitated anxiety, followed by an agitated depression.

These two cases are presented primarily as illustrative material and can be supplemented by many cases seen by the authors and by many cases among those reported by others.

Summary

1. The pre-psychotic personality of patients developing agitated depressions is described as the anal-compulsive character.

2. The development and characteristics of the anal character are outlined.

3. The agitated depressions are considered as the decompensation of an anal character.

4. The precipitating factors are considered to be traumata which prevent the maintenance of characteristically rigid ego defenses.

5. A differential comparison is made of the psychodynamics of the reactive and agitated depressions.

6. The psychopathology of the symptoms is related to the prepsychotic personality and its decompensation.

7. Two illustrative cases are presented.

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CHILDHOOD SCHIZOPHRENIA*

BY LAURETTA BENDER, M. D.

This discussion of experience at Bellevue Hospital, New York City, with childhood schizophrenia is presented because of the opportunities there to observe a large number of children that have been diagnosed schizophrenic, and because of the research work that it has been possible to do with them. This is not a review of the literature on childhood schizophrenia; but it should be recalled, nevertheless, that historically schizophrenia or dementia præcox has been considered characteristically a puberty psychosis, and its occurrence in childhood before puberty has been considered very rare. However, even Kraepelin[1] is often quoted, (Kanner[2] and Bradley[3]) as having said that in 3.5 per cent of adult schizophrenics clinical signs could be traced back to early childhood.

Bleuler has said: "Schizophrenia is not a puberty psychosis in the strict sense of the word, although in the majority of patients the sickness becomes manifest soon after puberty. With relatively accurate case histories one can trace back the illness to childhood or even to the first year of life in at least 5 per cent of the cases."[4] He also said, "If we observe patients during childhood, they present the same symptoms as those seen in adults."

In this regard, the writer would differ with Bleuler, except to agree that there are some children in whom this is true. We have to expect, however, many different signs and symptoms in schizophrenia in childhood from those in adulthood, just as we expect different signs and symptoms in postencephalitic, neurological and behavior disorders in childhood from those seen in adults. Bleuler further says[4] that the analysis of such youthful patients is much more difficult than that of adults, since we have not had adequate experience with techniques which are suitable for the youthful psychotic.

In the last 20 years, however, techniques have been improved for understanding the child—the child in general, and also the deviate child, including the child with schizophrenia. It was in 1933 that Potter,[5] then a member of the New York State hospital system, defined schizophrenia of childhood and stated it was more common

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than generally supposed, especially in institutions for mental defectives. Since then there has raged a controversy in this country as to whether childhood schizophrenia is the same as adult dementia præcox or whether it is a reactive pattern, such as the Adolf Meyer school of psychiatry has taught, reactive in particular to a cold emotional climate in the home during the first two years of the infant's life.

Kanner, of Johns Hopkins, has referred particularly to "early infantile autism"[6] as a response to refrigerator parents who cannot defrost.[7] He distinguishes this condition from Heller's disease, or an infantile dementia which is believed to result from a definite gliosis of the brain. Many workers related to the psychoanalytic schools believe that schizophrenia is dynamically determined like a neurosis, and speak of a withdrawal from reality, especially the disturbing reality of a poor mother-infant relationship (Despert,[8] Mahler[9]).

The most critical problems at the present time are: in the first place, to establish diagnostic criteria specific for childhood schizophrenia (that was what Bleuler implied); and in the second place, to carry on adequate follow-up studies which will determine the course of the childhood disorder into adulthood. For the purpose of further research and study, there are also many other important problems such as the etiological factors; dynamics, both psychological and biological; treatment and prognosis, and many philosophical problems related to human behavior. The first two, however, are the really critical ones at present. To repeat, they are to establish diagnostic criteria specific for childhood schizophrenia; and to follow up children so diagnosed into adulthood to determine the courses of their illnesses and the ways in which they have dealt with them.

It has been possible for me to make some sort of beginning in this direction since I have been working on the children's wards at the Psychiatric Division of Bellevue Hospital since 1934, or for more than 18 years.* At this time I shall attempt only to give a rather rapid and cursory survey of our follow-up studies as far as they have been completed, in order to show data relative to the incidence and course of childhood schizophrenia as we have seen

*I have had research support from the 33d Degree Scottish Rite Masons for about eight years, and from the Mental Health Institute of the United States Public Health Service for three years.

them at Bellevue, and evidence concerning the confirmation of the diagnoses made. Second, I shall present our current definition of childhood schizophrenia and a descriptive picture of the development of schizophrenic children, thereby illustrating the diagnostic criteria. The material at this time has been formulated principally as a basis for future study.

The follow-up data have been accumulated largely by the research teams that have worked with me in the past, especially in the last three years with the support of the Mental Health Institute of the United States Public Health Service, a team which consisted of three psychiatrists, two psychologists, a social worker, and a biometrician.†

From 1934 to 1951 inclusive, which is the period these figures cover, 6,500 children have passed through the children's ward at Bellevue. During that time, 626 have been diagnosed as schizophrenic (See Table 1). These children ranged in age from two to 13 years (inclusive). There were only a few in the early years of the puberty period, and, except for two, even those had been diagnosed as schizophrenic before they reached puberty. Of the total, 12 per cent were five years of age or under.

Table 1. Age and Sex Incidence of Schizophrenic Children Observed and Diagnosed on the Children's Ward of Bellevue, 1934-1951 (inclusive)

Age	Boys	Girls	Ratio: B G	Total
2	2	1	2	3
3	11	4	2.7	15
4	18	6	3	24
5	32	12	2.7	34
6	39	20	2	59
7	55	27	2	82
8	82	21	4	103
9	70	11	6.4	91
10	69	23	3	92
11	56	29	2	85
12	18	9	2	37*
13	3	8	0	11*
	455	171	2.66	626

*The drop in figures after 11 years is a selective factor, due to the admission policy on the ward, which is to accept children of 12 and over only occasionally.

†Alfred M. Freedman, M. D., Raymond Keeler, M. D., Betty Allen Magruder, M. D., Saul Gurevitz, Ph.D., Ilse Goldberg, Ph.D., Alvin E. Grugett, Jr., and William Helme.

Six hundred and twenty-six children out of 6,500, make a 9.5 per cent incidence in this ward group during this period. It is true that in the early years there were very few that were recognized; but in 1950, there were 127 out of a total of 316 children observed, or 40 per cent. This, of course, is an artificial situation, caused by the research programs, which have brought schizophrenic children to Bellevue, and by virtue of which, they have been readmitted frequently so that observation, treatment and follow-up studies could be carried on.

The sex ratio in this total group with schizophrenia is 2.66 times as many boys as girls. The ratio, however, of boys and girls that are observed at Bellevue in all categories is 4.5 times as many boys as girls, so that there is a distinct tendency within the schizophrenic children's group to come nearer to the 1:1 ratio than among the non-schizophrenic children. In boys, the highest incidence was in children of eight and nine, where the ratios were four and six times as many boys as girls; and the highest incidence among girls was seven and 11, where there were only two boys to one girl. (The data are not representative above the age of 11, since the older children are not usually admitted on the children's ward.)

In 1950-51, follow-up studies were made on 350 children who were observed between 1934 and 1946, so that the follow-ups covered from five to 15 years. These were grouped into several categories.

Forty-three children who were diagnosed as schizophrenics between 1938 and 1942 and had ranged in age from four to 13 received metrazol treatment. They were followed up in 1951 when they were in late adolescence or were young adults, ranging from 17 to 26 years of age.

One hundred who were diagnosed schizophrenic between 1943 and 1946, when they were four to 12 years of age, were treated with electric shock. These children were all pre-puberal when the diagnosis was made, and 85 per cent of them in 1951 were in the postpuberty period, ranging from nine to 18 years of age. This group of 100 electric-shock-treated children was reported on to the American Neurological Association meeting in 1947.[10]

There were 50 children who were diagnosed as schizophrenic during the same period, 1934 to 1946, who had not received shock treat-

ment, and 110 children observed during the same period who were not schizophrenic.

The analysis of the first 143 children will be given first, because they are the ones that we know the best, and these were reported at the American Neurological Association meeting in 1952. This was the group of children who received metrazol and electric shock and were followed up in 1951 to determine their present statuses and whether their diagnoses had been confirmed.[11] Studies have not been completed as to the evaluation of the shock treatment as such, although a little information can be given about that. The follow-up studies showed (Table 2) that we were able to get into contact with 120 of these individuals. They range in age as of December 1952 from puberty (11 years) to the late 20's.

Table 2. Follow-up Diagnoses on 143 Children Diagnosed (1938-1946, age 4-14) as Childhood Schizophrenia

Age 1951	Number	Schiz.	Ment. def.	Other type psychosis	Personality disorder	Additional schiz. (research staff Dx.— only available)	No diagnosis available
9-12	20	7	4	1	1	4	3
13-15	47	26	4	1	2	4	10
16-20	50	21	8	6	3	6	6
21-25	26	15	0	1	4	2	4
Total	143	69	16	9	10	16	23

Sixty-nine of these persons were in state hospitals where the medical staffs had diagnosed them as schizophrenic or dementia præcox patients of the typical adult type. An additional 16 were diagnosed mentally defective, but they were chronic inmates in institutions for mental defectives; and the diagnosis was admittedly an administrative one. All of the 16 were re-examined by the Bellevue research staff in 1951, which was not the same staff that made the original diagnosis, but was a special research group, and all were diagnosed as schizophrenia.

Nine were in state mental institutions, having been diagnosed as having some other form of psychosis, and 10 others as having some form of personality disorder such as psychopathic personality or a personality behavior disorder. Of these 19, 10 were re-examined by the Bellevue research staff; six were considered schizophrenic,

four as having some other psychosis or a personality disorder. In 16 other cases the follow-up diagnosis was made officially only by our own research staff, although several of these persons were recognized also by various authorities such as draft boards, schools or social agencies, as frankly schizophrenic. In the last 23 cases, we have still not been able to confirm the diagnoses, although, since this report was made in the spring of 1952, there have been three others accounted for, with their diagnoses confirmed. Several are in the community and un-co-operative with the follow-up study, although regarded by the family, or often by a supervising agency, as disturbed, or showing serious symptoms.

Therefore, by the most severe criteria—that is, recorded diagnoses by another medical staff—66 per cent of the 104 patients later evaluated by state hospital staffs were found to be adolescent or adult schizophrenics.

Diagnoses have been confirmed by our own staff in another group of 38,* bringing the confirmation to 87 per cent (spring 1952) or to 89 per cent (December 1952); and the remaining 13 per cent are not proved not to be schizophrenic.

To give data about their adjustment, about two-thirds of the child schizophrenics have required state hospital care subsequent to their care in Bellevue. One-half of them went directly from Bellevue to some state institution, and one-third of the total group have remained continuously, and are still, in state hospitals or other state institutions.

At the beginning, 50 per cent remained in the community. Of these, some went back into the hospitals, and of those in the hospitals, some returned to the community, so that 50 per cent are now again in the community. Twenty-five per cent of the 50 now in the community are showing a fair-to-good adjustment. Consequently, one may prognosticate that where the diagnosis of childhood schizophrenia is made before puberty, a 50 per cent favorable, though often somewhat limited, adjustment may be anticipated.

The 50 children who were diagnosed schizophrenic during the period under study but who did not receive electric shock have been found the most difficult group to follow up. It was expected to have a control group of 100, but the research staff has had to be

*These 38 include the 16 patients seen in follow-up by the research staff only, plus the 22 considered schizophrenic by the research staff but otherwise classified by other staffs.

satisfied so far with 50 although it had proved possible to follow up the 143 in the shock-treated groups. The reasons that the control group proved elusive were in part the same reasons for their not having received electric shock treatment. These children had not received it for the following reasons: 10 per cent were diagnosed (1934-38) before the shock treatment program started. At that time, the diagnosis was made only on the most severe cases. Of these most severe cases, another 10 per cent were considered unsuitable for treatment because they were too paranoid and un-co-operative, especially around the pre-puberal period; 15 per cent were considered mild cases and possibly able to get along without treatment. There has always been great resistance to treating cases with shock where anyone has any doubt about the diagnosis.

On the other hand, 65 per cent were recommended for treatment, but their parents refused permission. It is among this largest proportion that there has been the poorest response to later attempts to obtain the necessary co-operation for follow-up study.

Confirmation of the diagnoses within this group of 50 non-shock-treated individuals has been made by other hospital medical staffs. Of the 42 patients who were evaluated later, 28 were diagnosed schizophrenic, eight were considered mental defectives (two with psychosis associated), three were diagnosed psychopathic personalities, and three have other diagnoses. Eight, although the research staff knows their whereabouts, have not been available for examination.

Of the 28 diagnoses that were confirmed by outside staffs, the Bellevue research staff saw nine patients, and agreed with the diagnoses, but it was not possible to see any of the other individuals.

Interestingly enough, the course of these 50 non-shock-treated cases is in many ways similar to the other 143 shock-treated cases, except for some differences the writer would like to point out. Two-thirds of the non-shock-treated group were subsequently sent to state hospitals. In most instances, they did not go immediately from Bellevue to the state hospital, for the same reasons that they did not receive treatment: lack of co-operation on the part of the parents; disagreement between the parents and the Bellevue recommendations; or, maybe, it was Bellevue that did not co-operate. One-third of the group remained chronically in state hospitals and were reported to be emotionally flattened with minimal adjustment. Five were definitely deteriorated.

These are practically the same proportions as for the 143 shock-treated individuals: that is, two-thirds were at some time or other in the state hospital and one-third were still in the state hospital in a poor condition. The patients who were not treated, however, did not go to the state hospitals until later. Another difference is that among these non-shock-treated patients it was possible to learn of only two who are presumably, from hearsay, making fair-to-good adjustments, whereas about one-fourth of the 143 shock-treated patients are making fair-to-good adjustments, and some are making good adjustments.

There were also 120 non-schizophrenic children that were followed up because they represented problems other than schizophrenia that interested the research workers, and that had had papers written about them. These children were followed up in part to determine the importance of their specific psychopathology* and also to give us control material for the schizophrenic studies.

These children were reported under certain descriptive categories. There were papers on aggression in children by Schilder and myself,[12] and 10 of these children were followed up; and on children with suicidal tendencies,[13] 16 of whom were followed up; and one on children with homicidal tendencies or who had actually committed homicide,[14] by Curran and myself, 15 of whom were followed up.

There was a paper on fire-setters in children[15] by Yarnell, and 13 of these were followed up. There was one on children with hallucinations[16] by the writer and Lipkowitz, and one on imaginary companions[17] by the writer and Vogel. In each of these groups, 12 were followed up. There was a paper on impulsions and compulsions[18] by Schilder and the writer, one on obsessions[19] by Berman, one on sexual confusion and homosexual tendencies in children[20] by Paster and the writer, and one on children who had sexual activities with adults by Blau and the writer.[21]**

In all, there was a total of 120 children who were not considered to be schizophrenic when they were studied under these various

*These papers and the follow-up studies are being published in two books: *Aggression, Hostility and Anxiety in Children*, and *Dynamic Psychotherapy of Childhood*, published by Charles C. Thomas. 1953 and 1954.

**The follow-up study of these children with atypical sexual experiences has been reported by the writer and Grugett (Ref. 22).

headings; 25 per cent of these turned out to be schizophrenics in the follow-up study in 1951.

In this group, the ones most likely to be schizophrenics were those with pre-puberty psychosexual confusion or homosexual trends, preoccupations and problems; those who had impulsions, compulsions, and obsessions; and those with suicidal and death preoccupations.

Interestingly enough, children with hallucinations and imaginary companions, were least likely to be schizophrenic; and, if they were, they had excellent prognoses.

Out of this group of non-schizophrenic children, 30 have been selected-controls for 30 of the schizophrenic. A statistical analysis has been made of the diagnostic criteria, comparing the two groups, showing statistically (material which is not presented here*) a definite validity of the diagnosis of schizophrenia as against the non-schizophrenic problem child. In this study only those symptoms were used which were evident when the child was first seen and before he received shock treatment, and which were recognized under conditions which were different from the present, inasmuch as we did not then have the understanding of the symptomatology we now have.

The data were found to be confirmed, especially in regard to those symptoms which can be called nearest to the biological phenomena of the individual, such as vasovegetative, motility and form-perception disturbances, in contrast to those which might be called psychological reactions or related to psychogenic factors.[11]

From this introductory survey of the studies we have been making in connection with the life courses of children diagnosed as schizophrenic, we may pass on to the second area mentioned in the beginning: the question of diagnostic criteria. Bleuler said that the difficulties lay in finding techniques suitable for analyzing childhood psychoses and so suitable for evaluating observations and determining therefrom the diagnostic criteria.

In the course of recent years many new areas have been added to our experience, areas which have made it possible to develop new diagnostic techniques, and some of these will be mentioned in passing.

1. We have understood more about motility patterns in children, how a motility pattern develops and what it means in terms

*To be published: Bender and Helme (see Ref. 37).

of neurological integration, and deviations and their significance, including impulse disorders. These are things that have come particularly from the experience and teachings of Schilder.[23]

2. We have learned about body image concepts or the child's developing concept of its own body as it functions in the social and physical world, and its relation to the motility problems. This, too, was Paul Schilder's concept.[24]

3. We have learned much about maturational patterns, especially as they are derivations of behavior from embryological patterns. This is the work of Gesell,[25] and this, particularly, has contributed in the last two or three years to my personal understanding of childhood schizophrenia.

4. We have acquired increasing knowledge about perceptual motor integration by patterns and by the use of projective techniques for the study of such patterns, their maturation and deviations. These are the contributions of the Gestalt school of psychology. A visual motor gestalt test which I have developed has been useful in our hands.[26]

We have learned more about the dynamics of personality development and its deviation, including such phenomena as identification, introjection, ego boundaries, reality testing, and fantasy formation. This has come especially from psychoanalytic contributions concerning children, genetic psychology, and ego psychology. (See especially Melanie Klein.[27])

We have learned more about anxiety in infancy and defense mechanisms with secondary neurotic symptomatology. In this regard, one is reminded of the more recent work on pseudoneurotic schizophrenia in adults which throws considerable light on the problems we also see in children. (Hoch and Polatin[28].)

With the armamentarium which can come from these new points of view and new techniques, we can approach the problem of deviate-child behavior and analyze our data in the very way that Bleuler complained could not be done before. It is as a result of the background of this material that I have come to the formulation of schizophrenia with which my name has been associated.

Again it would be well to give you a little history, as it will, perhaps, make a little clearer what we have arrived at.

In 1942, childhood schizophrenia was defined[29] by me and our group at Bellevue as a clinical entity occurring before the age of 11, which revealed pathology in behavior at every level and in

every area of integration or patterning within the functioning of the central nervous system. The vegetative, motor, perceptual, intellectual, emotional and social areas were all involved. The important thing in making a diagnosis of childhood schizophrenia is to realize that one symptom does not make a schizophrenic child; the typical symptomatology must pervade in every area of functioning.

Furthermore, this behavior pathology disturbs the pattern of every functioning field in a characteristic way. It was further defined at that time as a form of encephalopathy occurring at different points in the developmental curve and interfering with the normal developmental pattern of the biological unit and of the social personality in a characteristic way, causing anxiety to which the child must react, according to his own capacity, with neurotic defense mechanisms.

In 1947, the deviation in behavior was studied in different areas such as vasovegetative, homeostatic function, and growth areas; motility and motor development; perception; thought; language; symbol formation; and specific psychological problems at the different age levels of schizophrenic children.[30]

In 1949, this definition was modified by adding the concept of plasticity.[31] That is to say, a specific pattern of disturbed behavior in each area of function is best understood if one considers a high degree of plasticity as the primary feature of the schizophrenic process in the child. With this one then can best understand most of the symptomatology of the schizophrenic child and the wide variety of clinical pictures in different schizophrenic children.

Thus, some schizophrenic children are regressed, retarded, fixated, blocked, inhibited, mute, autistic, withdrawn, physically asthenic, puny or under-developed, unsocial, unable to relate, concretistic in their thinking; but there are other schizophrenic children who are just the opposite. They are precocious, develop too fast, have an exaggerated intellectual brilliance, are overactive and cannot be suppressed in their activity. They have precocious language development, are highly articulate, and often show special gifts, especially in language, the graphic arts and dancing, and in their insight into psychological problems. They tend to overidentify in any group and they relate too well. These children call forth strong counter-transferences from adults. They are excessively abstract in their thinking. Some children go

through phases of these extremes of behavior, while most of them show mixtures of the tendencies, although one or the other may predominate. This plasticity can best account for the variety of pictures which I have diagnosed as schizophrenic and which, as my figures show, we have been able to confirm as subsequently being adult dementia præcox.

The outstanding psychological problems of the schizophrenic child have to do with body functions, motility, body image, identity, and object relationship, all of which are distorted by the schizophrenic process, although all of them represent exaggeration of the problems of normal children during development. The resulting anxiety is the most apparent sign of suffering and is a true danger sign of the threat of disintegration of a personality. This anxiety tends to express itself through all of the schizophrenic disturbances and also in neurotic symptom formation. The latter may be the presenting symptom. Experience has led to the conclusion that any severe psychoneurotic disorder in a child before puberty, whether it is obsessive-compulsive, so-called hysterical or simply severe anxiety, is a reactive response to a deeper, inherent threatening disorder, most often schizophrenia, although possibly some other organic brain disorder.

In the last two or three years, the writer's concept[32] of childhood schizophrenia has been greatly influenced by the work of Arnold Gesell, especially by his book, *Embryology of Behavior,* which appeared in 1945.[25] On the basis of his observations of fetal infants he maintains that all behavior evolves from five basic physiologic functions. These functions are the prerequisites of all future behavior. They are classified as follows: (1) homeostatic mechanisms; (2) state of consciousness, sleep and waking patterns; (3) respiration patterns; (4) muscle tone; and (5) tonic neck-reflex attitudes which underlie all motor behavior.

For example, Gesell describes the early fetal infant—that is, of 28 to 30 weeks postconception—as torporous. The torpor is fluctuant and shallow. He neither sleeps, nor is he awake. He is flaccid with a minimal uneven tone. His breathing is shallow, irregular, and out of tempo with his needs. Postural movements are sporadic. He shows an attitude of accommodation to the rounded walls of the uterus, an occasional impulse to elevate an arm into a floating tonic neck reflex posture, stretching, relaxing, and arresting movements into occasional catatonic postures. Response

to sensory stimuli is evidenced by the fingers flexing on the touch of a rod to the palm of the hand and waves of vibratory activity in response to sound. The most conspicuous behavior trait is ever-recurring torpor.

Gesell goes on at each level and describes the fetal infant in the next four weeks as a little less moluscus, more compact, and with some tonic neck reflex movements with arms floating and head turning.

The late stage fetal infant shows some homeostatic "wisdom," an effort at rhythm of activity and rest, and some knack of sleeping. The head rotates in supine position, and the whole body takes on spontaneous movements of the tonic neck reflex type.

In the newborn, breathing is irregular and the pulse variable. The intestinal tract is hyperactive, and there is poor control of body temperature. At one month the infant is expected to have better homeostatic control, more compact tone; it braces itself to be lifted, responds to social attention, gets a pattern of sleep, wakefulness, respiratory rhythm, feeding and elimination. Tonic neck reflex motility occurs as a part of the startle reaction, but gives way to more intricate behavior, involving grasping, sucking, turning of the head to stimuli, etc.

When one studies the schizophrenic infant, which we have done so far largely from the careful biographical notes of intelligent mothers and from pictures—and more recently some of the younger ones personally; the research staff has been seeing such children, one of them under a year, some between one and two years, a number between two and three years—we find that the schizophrenic infant retains all of the early embryological features which have been outlined for the fetal infant by Gesell. Even as the child continues to develop somatically, intellectually, and also in his neurological integration, he carries along with him these embryological characteristics of primitive homeostatic control, primitive patterns of sleep and wakefulness with waning states of consciousness, primitive tone, and a tonic neck-reflex dominance of all motility.

Anxiety is these children's first response and may be unremitting from the first day of life, or, of course, it may appear at any time later. Secondary neurotic habit patterns may be evident from the early months and are evidence, of course, of the struggle for ego maturity and the struggle for health. On the other hand, the in-

fant may succumb to a more or less completely unpatterned torporous state, with a retarded ego and intellect.

There is one other factor in relation to primitivity that must be appreciated. If there is a retardation of the personality of the total biological organism—thinking of personality as a biological unit—to a primitive level, then the concept of plasticity applies especially. Anything that is primitive may not only be retarded but also may have unlimited capacity for development. It is this very primitivity which makes it possible for some children to overshoot in their development, to become precocious, gifted, and overactive, and to show all of the various over-responses which already have been described. And, of course, we have seen all sorts of combinations of these patterns.

The secondary psychological problems which develop in the schizophrenic child have to do with difficulties in the body image concept, difficulties in object identification, or in identifying himself with reality, and difficulties in handling his anxiety. These become the three major problems for the child.

The full description of all of these problems will not be gone into at this time, and the writer finds it easiest to be articulate about the body image problems. The schizophrenic child's body has not acquired homeostatic wisdom, and his nutritional and eliminative patterns may not be readily established. He may be a feeding and toilet-training problem. He tends to have oral and anal fixations. His pulse and temperature control are not adequate. His vascular system is labile. His development curves are uneven. He is subject to the so-called allergies, colics, coeliac disease, recurring respiratory illnesses, gastro-intestinal illnesses, skin disorders: that is, all of the psychosomatic disorders.

Such a child becomes hypochondriacal and aware of his internal organs and functions. His sleep patterns are not well established. He is restless at night, subject to night activities, anxieties, nightmares, tantrums. He dreams and fantasies about sleeping, waking, fainting, dying, disappearing and having blackouts. His respiratory patterns are not regulated. This leads further to subjection to more of the things just described, these disturbed states of consciousness, anxieties, preoccupations about death. Also immaturities in speech, language and thought may be related problems.

A normal body tone is never acquired. The child's physical contact with the objective world is not distinct. He and it tend to

melt into each other. From this arises, some of the body boundary problems or ego boundary problems, and the fear of incorporating or being incorporated. This, of course, is the psychoanalytic material which has been known for some time. The schizophrenic child tries to escape from gravity, often by climbing high, whirling, running away, darting, and what not. Or else he is fearful that he will escape from gravity and fly off into space.

The tonic neck-reflex impulses dominate his motility so that he is always subject to impulses to whirl or go out into space, or else he must resist these. He has difficulties in object identification, and has anxiety obviously derived from all of these problems, together with other problems which are as yet too difficult to formulate.

Consequently, our present formulation of a definition for childhood schizophrenia is a developmental lag of the biological processes from which subsequent behavior evolves by maturation at an embryological level, characterized by an embryonic plasticity, leading to anxiety and, secondarily, to neurotic defense mechanisms.

In regard to the question of etiology, it has already been mentioned that there is a controversy as to whether childhood schizophrenia is a reaction to inadequate parent-child relationship or if it is akin to adult schizophrenia or dementia præcox. The writer has been tremendously impressed with the heredity factor. The data on heredity have not been fully collected or analyzed, but even the incomplete material has important implications. Of 143 schizophrenic children we followed (the groups that received metrazol and electric shock treatment), 57, or 40 per cent, are known at the present time to have one parent with a definite or suggested diagnosis of schizophrenia in the records; 15, or 10 per cent, are known to have both parents with such a recorded or suggested diagnosis; 11 have siblings under treatment for schizophrenia. In the past three years, several pairs of identical twin children in which both children were schizophrenic have been observed at Bellevue. In these respects our clinical experiences and impressions agree with the conclusion of Kallman's studies on the genetic theory of schizophrenia.[33]

The etiological factor which is most important in precipitating the schizophrenic illness is a physiological crisis, such as birth, es-

pecially with damage such as anoxia; severe illness or accidents; and the pre-puberal and puberal, crises.

The parent-child relationship or the emotional climate of the family, especially in the first two years, will help determine the defense mechanisms, the ability to handle regressive tendencies, impulses, anxiety, etc. In other words, no child can develop schizophrenia unless predisposed by heredity; the psychosis is precipitated by a physiological crisis; the pattern of the psychosis and its defense mechanisms are determined by environmental and psychological factors.

Now as to the question of treatment; with the definition of maturational lag plus plasticity, plus anxiety, plus defense mechanisms, the treatment approach may be more clearly defined. This will mean that therapy which aims to break down neurotic mechanisms and give insight into neurotic dynamics, is contraindicated.

Treatment should, if this definition of childhood schizophrenia holds, aim, in the first place, at the stimulation of maturation; second, at the patterning of plasticity; third, at the control or relief of anxiety; and, fourth, at the strengthening of defense mechanisms.

Therefore, treatment may include shock treatment which seems to be stimulating to maturation and to the patterning of plasticity. We have considerable evidence from clinical follow-up studies, from EEG reports, Wetzel grids and from other areas, in this direction.

Drugs may be used to help the child control his impulses, to pattern plasticity, and to stimulate maturation.

Psychotherapy should certainly be used, but it should be of the kind which stimulates neurotic formation and does not break it down—or rather helps the child to develop a useful or social form of neurotic formation.[34]

Group experiences away from the family conflict, at least for a period, may be both stimulating to maturation and helpful to the child.

Treatment of the parents,[35] especially in groups as we have often done at Bellevue, will help them understand their problems.

One of the most interesting treatment experiences which we have had, and which has shed a great deal of light both theoretically and practically on the situation, has been with schizophrenic children who also had reading disabilities.[36] Our concept of a reading disa-

bility is that it, too, is a maturational lag in the specific areas of language. We know what to do about reading disabilities. They call for tutoring in a specific way by a specially trained tutor who can also relate to the student. Consequently, when we have had schizophrenic children who had reading disabilities and we gave them specific tutoring for their reading disabilities, we not only cured or improved them in relation to the reading disability but we also improved them dramatically in relation to schizophrenia.

This, therefore, leads to the possibility of our studying schizophrenic children for other areas of specific maturational lags, and treating those lags specifically, through, of course, a person who relates to the child—not to interpret dynamics or to break down neurotic patterns—but to help with the specific disability and with the general maturation problem which is the schizophrenic disorder.

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EDITORIAL COMMENT

"ALL HIS FANCY"

"It's all his fancy that," said the Gryphon of the Mock Turtle, "he hasn't got no sorrow, you know." But the Mock Turtle sat "sad and lonely on a little ledge of rock," his "large eyes full of tears." He was "sighing as if his heart would break."

No one would pretend that this sort of thing ever completely described the popular attitude, still less the general medical attitude, toward mental and emotional illness. But casual readings or conversations on this topic readily reveal that it still remains an element in some popular and, one regrets to say, some medical thinking as well—particularly in regard to those minor mental illnesses which do not generally lead to hospitalization. The term imagination is still used to describe the source and/or cause of many neurotic symptoms, and it is still believed, even by some medical men, that cure is effected by the patient realizing that the cause is not organic and by either stopping the process of "worrying about it," or even more simply by "forgetting it." Would that the cure were so simple, but the actual experience of specialist after specialist, and general practitioner after general practitioner, proves that it is not.

This point is raised here because there is reason to wonder if our mental hygiene educational campaigns and lectures should not strengthen their efforts to make it plain to the public and all medical personnel concerned that mental disorder is—in every sense of the word—real. It is a matter brought to mind by, of all things, a textbook of cardiology in which a cardiologist discusses a common "heart neurosis" in such enlightened fashion as to bring sharply to professional attention just how uncommon such discussion is.

The cardiologist is Lt. Col. Weldon J. Walker (MC) U. S. A., contributor of a chapter on neurocirculatory asthenia to a new medical text, *Clinical Cardiology*,* of which Franklin C. Massey, M. D., is editor. Colonel Walker emphatically does not belong to

**Clinical Cardiology.* Franklin C. Massey, M. D., editor. Williams & Wilkins. Baltimore. 1953. (Chapter on "Neurocirculatory Asthenia" arranged and reprinted by *Current Medical Digest*, May 1953.)

the school of those who exhaust the repertoire of examinations and tests and then tell the patient triumphantly: "You will be very glad to know that there is nothing whatever wrong with your heart; I have given you a most careful and thorough examination, and your heart is in perfect condition; there is nothing serious wrong with you; you can stop worrying." But the patient has symptoms of exhaustion after slight effort, breathlessness, palpitation, faintness, throbbing, left-side thoracic pain and syncope. He knows very well, whatever the doctor says, that there is something serious (in the sense of painful, frightening and crippling) wrong with him—and so, of course, do we. And so does Colonel Walker, who believes not only in telling him so but in telling him what it is. And, "It is important," he writes, "that the diagnosis be made at the time of the first examination."

Here is a cardiologist who looks for the symptoms of neurosis (or psychosomatic disturbance) at the same time and in the same way that he looks for the symptoms of organic heart disorder in obtaining a medical and personal history and making a complete physical examination. If he finds the characteristic symptoms of neurotic disturbance, he tells the patient so, and tells him promptly —lest the patient feel that the diagnosis of the one has been made merely by exclusion of the other (and candor would compel most of us to admit with some embarrassment that we have seen diagnoses made just that way). "It is important," says Colonel Walker, "that a positive diagnosis be made before doing the laboratory studies—the physician thus shows confidence in his diagnosis, and as each normal laboratory study is reported, the patient's confidence in the physician is increased. If he orders extensive laboratory studies without telling the patient he expects them to be negative, with each normal finding, the patient's esteem for the physician will drop. The patient assumes the tests were ordered to 'find out what was wrong.' When the physician finally tells the patient his symptoms are due to nervous factors, it appears he is saying this because he has been unable to find anything abnormal with the tests. To the patient, it looks like an alibi, his confidence in the doctor is shaken and the usual story is for him to consult a different physician who, too often, 'does some different tests.' "

Here is an example of an explanation to a patient: " 'Mr. Jones, after a thorough examination I do not believe you have any serious heart disease, although you have suffered from distressing chest

pain and are naturally concerned about it. The pounding and skipping of your heart, I believe, results from a nervous reaction rather than from disease in your heart. For instance, if you walked down a dark alley at night and a masked bandit suddenly stuck a gun in your ribs, I am sure your heart would beat very fast and hard—not because it was bad, but in response to the nerve impulse that went out because of the fear you were experiencing. Your breath would also come short and fast and your hands would be wet and shaking as they were when you came into the office. Prolonged worry, tension, anger or anxiety can produce the same nervous impulse as intense fear. That this is probably a factor in your case is suggested by the appearance of your symptoms shortly after the arrival of the new foreman with whom you are having trouble. The pain beneath your left nipple probably results from forceful beating of your heart against the chest wall, perhaps from spasms in your muscles of breathing. You are afraid that your heart is bad, and as a double check I suggest we get an electrocardiogram, chest x-ray, blood test and urinalysis as a part of a complete medical evaluation. I expect they will be normal and even if they aren't, I am sure most of your symptoms result from nervous causes since no form of heart trouble can completely explain your symptoms while a tension state readily can.'"

This is eminently reasonable, and ought, one thinks, to be convincing. It ought, for one thing, to prepare the patient for the psychotherapy Colonel Walker thereupon recommends that the doctor give, for he remarks, "it is obvious that no conceivable growth of psychiatry will provide care for all these patients [his estimate is that between one-third and two-thirds of patients who consult physicians have psychological disorders]. Neither is it desirable. It is apparent that each of us must become 'minor psychiatrists' and treat the less severe cases and refer the major ones to experts in the field." As procedures the "minor psychiatrist" may employ, he lists such important matters as acceptance, support, understanding, environmental manipulation, release of emotions, explanation, reassurance, suggestion, persuasion, desensitization and re-education.

Most important of all, the specializing psychiatrist himself may think, Colonel Walker recognizes the patient's psychological difficulty as real. There is a world of difference between explaining to Mr. Jones the psychological source of the difficulties that he

finds are so frightening and crippling, and telling him, "There is nothing whatever the matter with you"—with its implication, "You are certainly a jackass, Mr. Jones."

It seems likely that we have not yet laid enough stress in mental hygiene efforts on the fact that it is unenlightened, fruitless, and possibly even sadistic, to belittle the mental or psychosomatic patient. Colonel Walker suggests that the physician who lacks respect for the psychosomatic or neurotic patient, perhaps thinking the poor fellow is simply made of "poor stuff" and that efforts to help will be wasted, should study his own psychosomatic reactions: "Such a physician's viewpoint may change if he will make a careful assay of his antecedent emotions the next time he experiences a headache, pounding of the heart, insomnia, wet sweaty palms, or abdominal pain, especially if he has eaten when extremely angry. After personally recognizing the relationship between one's own emotions and some of these manifestations, it is surprisingly easier to view them as the normal physiology of emotional expression."

It leads one to wonder if, with all our efforts at public and medical education, we have succeeded in stressing sufficiently the bitter realities of suffering and need for treatment of patients in whom organic pathology does not exist or is not demonstrable. The illustrations Colonel Walker gives are few and sketchy: They could be expanded encyclopedically. It should be possible to give insight to anybody who has ever had a nightmare as to the reality of hallucinations; to make anybody who ever, as a child, stood helpless and trembling with fear, feel the reality of a paralyzing anxiety reaction; or to make any medical student, nauseated by a dissecting room, comprehend the effect of environmental or psychological factors on the gastro-intestinal system. But one suspects that Frank Fay and James Stewart in *Harvey*, through converse with a pleasant (and somewhat exceptional) hallucination, did more to give general insight into the reality of this common—and most often distressing—phenomenon than all our educational endeavors. And the however inaccurate term "battle fatigue," as representing the unbearable intensification of efforts, tensions and stresses that everybody can feel he has experienced himself, has helped, one may believe, general understanding of the reality of neurotic and psychosomatic phenomena.

It should not be impossible eventually to convey generally the idea and the feeling that even in dealing with such a thing as hypo-

chondriasis, physicians are dealing with a reality that calls for respectful recognition and understanding by the physician and that may call for serious psychiatric treatment. To adapt the text for nursery school, one does not accept the hypochondriac's belief that he has cancer, "heart trouble," or "weak lungs"; but one does accept the reality of his belief, the reality of the fear, guilt and anxiety behind that belief, and the need of psychotherapy, not placebos, to restore a panicky patient's healthy functioning. World War II has supported evidence from World War I that even such calculated obstructiveness as malingering has psychological bases in reality and represents a mental condition calling for psychiatric, as well as, or maybe instead of, disciplinary action.

What is of concern here, however, is less the soundness of the psychiatric principles presented in *Clinical Cardiology* than the place and purpose of their presentation. The place is a textbook addressed to non-psychiatric specialists and general practitioners; the purpose is to stress, from a non-psychiatric point of view, the extent of the psychological disorders encountered by cardiologist and general practitioner; and to outline diagnostic criteria and treatment for a specific psychological disorder which affects the functioning of the heart.

Neurocirculatory asthenia is discussed like any other condition affecting the heart; its differential diagnosis is outlined; its treatment is summarized. The patient is told what is wrong—in non-invidious terms. He is recognized as a sick man, which is true, not as poor stuff which is not necessarily true. Furthermore, treatment needs and methods are then set forth.

With the general principles and most of the specific recommendations set down for treatment, the specialist in psychiatry will find little to disagree. There would certainly be some to take issue with the suggestion that the patient be asked to *write* a brief life story the *second or third* visit, as by no means the best procedure. But: *"The physician's entire attitude should be concerned with understanding, not judging the patient.* He need not determine what is 'right' or 'wrong,' 'good' or 'bad.' It is not the physician's task to dig out confessions, or to discuss sexual experiences prematurely. He should create an atmosphere of trust and confidence into which the patient will spontaneously bring his sensitive, anxiety-laden experiences, memories and fantasies. . . . Reassurance is more effective when offered sparingly and thoughtfully, rather

than frequently and glibly," These are the basic principles of sound psychiatry, and one may believe that they have been observed without exception by all the great psychotherapists. It might be difficult to find, in texts intended for the training of psychiatrists themselves, a better statement of the discipline's philosophy of psychotherapy.

Practically, one may entertain doubts of these proposals. Perhaps our cardiology text presents an ideal, rather than a practical program. Besides the author's estimate that from one-third to two-thirds of all patients who consult physicians suffer from psychological illness (and the estimate commonly seen is nearer the higher figure), he notes that neurocirculatory asthenia alone has been "estimated as the sole disability in from 10 to 50 per cent of patients who visit cardiologists." One wonders what proportion of general practitioners and cardiologists, assuming the latter do the psychotherapy for their own patients, are fitted by training, temperament and sense of responsibility for the role of "minor psychiatrists" that the author envisions—there are psychiatrists themselves who are not. One wonders how many would have the time required for even simple brief psychotherapy—there are enough practitioners now who give the impression that only a combination of cigarettes and hypomania enables them to cope with the overloaded practices they maintain. And one wonders what program of medical school and postgraduate psychiatric education could be devised to make up for these deficiencies. Finally, psychiatry and psychosomatic medicine are severely enough pressed now; could they handle the burden if practitioners everywhere began to pass on to "experts in the field" the "major" cases which proved too much for "minor psychiatrists"? There is reason to think that these would be no small fraction. But this discussion is less concerned with what look like enormous practical difficulties in the future than with this present honest and enlightened presentation to general medical people and to specialists in another field of an important psychiatric problem. It would be a tremendous stride, psychiatrically and medically, if practitioners everywhere were merely to recognize the problem, endeavor to diagnose emotional disease as carefully as physical, and explain it to its victims in non-invidious terms. And such terms often suggest themselves readily: Few patients' acquaintances are likely to jeer at such recognized diagnostic descriptions as "neurocirculatory asthenia,"

"effort syndrome" or "Da Costa's syndrome"—or, in another than the cardiac field, at "spontaneous hypoglycemia" or "cryptogenic hyperinsulinism." Or where non-derogatory medical terms do not readily suggest themselves, a patient may willingly accept the reasonable attribution of his tension, insomnia and lack of appetite to home conflict between his wife and mother, tension over his job, or some other reality factor.

The first consideration in this discussion of the diagnosis of emotional disorder has, thus, been presented as respectful consideration of the patient. Aside from reluctant school children, there is little malingering in civilian medical practice; the person who fantasies an illness as an excuse to stay away from work is likely to keep as far away as possible from a doctor. The vast majority of those who seek medical attention feel ill or think they have good reason to believe they are ill. Whether the illness is emotional or physical, psychiatrists will agree with Colonel Walker that the most important element in the attitude of the physician consulted is "*respect* for the patient." And respect for the patient does not include telling the victim of emotionality, "There's nothing the matter with you, [and expressed, if unspoken] you poor fool." One can as readily say, "This attack (or condition) is caused by worry (or tension, or anxiety, or sorrow). It is distressing, but we can take care of it; this and that are what I want you to do about it." Such respectful honesty, one might maintain, is the due of the hypochondriac, rather than consent by silence to his belief in non-existent physical illness; it is certainly no worse therapy to explain to such a person that his fears are brought on by anxiety than to encourage his delusions; the explanation will not cure, but neither will sugar pills nor laparotomies.

That mental disturbance, great or small, is nobody's "fancy" but should be recognized in matter-of-fact fashion as illness, referred to as such, and treated as such, is one of those self-evident, elementary, simple propositions that one takes for granted—and blithely disregards. The physician's happy tendency of pooh-poohing patients' complaints in the absence of physical findings—rather than diagnosing and explaining minor psychosomatic disturbances—is one of the cornerstones in the structure of non-medical quackery and charlatanry. If a patient does not turn from the doctor "who doesn't know what is the matter" with him to another doctor who

will "make some different tests," he may turn to the quack who pretends to know all about his difficulties. Greater practice of realism in medical diagnoses should deprive the quacks and cultists of much revenue and so contribute to general public health as well as to general mental health.

Perhaps it would be well to provide a little more backbone here as evidence that the fellow who diagnoses "all his fancy that" is something more than a straw bogey clothed in medical trappings. Consider hysteria, a disorder named for the Greek word for the uterus and once mistakenly supposed to be confined to women, a source, incidentally, of some medico-legal folklore. The undergraduate psychology courses of some thirty years ago used to cover the subject of hysteria by relating that it mimicked real disorders. This never-too-plausible and wholly inaccurate explanation is, astonishingly, still current. A well-known medical authority, writing for the general public—and repeating, by the way, the antique belief that hysteria "is limited almost entirely to women"—notes that "almost any disease can be imitated by hysteria . . ." and, discussing needless operations on hysterics, says, "hysterical manifestations mimic disease so closely that the real cause does not become evident until the incision is made." In other words, hysteria is not a disease, it is not "real," it only mimics something that is; one can only wish the good doctor would talk over the matter with psychiatrists who are baffled daily by it. As it is, he does not even suggest in this discussion that it calls for treatment.

One might as well here anticipate objections that telling patients with minor functional disorders that they are really ill will increase the incidence of iatrogenic illness. The psychiatrist, who must endeavor earnestly to convince the patient that he is really ill as a first step toward giving him insight and so making therapy possible, is not likely to take fears of increased iatrogenic illness too seriously. Which is more likely to produce such a disturbance: a patient's fear that he has a serious and mysterious illness which his doctor is too ignorant to recognize and treat, or a patient's knowledge that he has a minor emotional disorder which his doctor understands and is prepared to deal with?

The gain to mental hygiene alone from a better diagnostic procedure should be considerable. Patients whose doctors have diagnosed their stomach upset, insomnia or headache as caused by

simply-explained emotional factors will be readier with understanding that similar emotional factors can cause a frankly neurotic neighbor's queer behavior or a hospitalized psychotic relative's florid delusions. The understanding that minor emotional disorders are so widespread should do much to reduce still-prevalent fears and superstitions about the major derangements.

It is not all their fancy, that! Knowledge that the doctor is willing to recognize their illnesses as real, to diagnose them, and to treat them, should set many persons more firmly on the road to mental health.

BOOK REVIEWS

Shock Treatments, Psychosurgery, and Other Somatic Treatments in Psychiatry. By L. B. KALINOWSKY, M. D., and P. H. HOCH, M. D. 396 and xii pages. Cloth. Grune & Stratton. New York. 1952. Price $8.75.

The discussion of the use of shock treatments, psychosurgery and somatic therapy in psychological disorders indicates the obscurity of their modes of action. Although the theories are not entirely satisfactory, empirically the methods in use do modify the disorders, sufficiently to maintain interest and research in the field. Therefore, there is need to review various concepts and experiences at certain stages in progress.

Kalinowsky and Hoch have presented an admirable compilation, summary and discussion of the literature and their own experience in their second enlarged and revised edition.

The bibliography of 52 pages indicates the extensive specific literature that was reviewed. The index of 16 pages is sufficiently detailed to allow rapid access to particular phases of material and discussion.

There is so much material to absorb that, although this is slow reading, it is greatly rewarding, especially if used as a reference book.

The text is well organized, clearly written, inclusive and up-to-date. It is recommended to all persons interested in mental disorders.

How to Make Your Daydreams Come True. By ELMER WHEELER. xii and 195 pages. Cloth. Prentice-Hall. New York. 1952. Price $3.95.

How to Make Your Dreams Come True, by Elmer Wheeler, is a mixture of pseudo-psychology and strong common sense. While it is intelligent in approach, it is coupled with naïve viewpoints in argument and attitudes. Yet it is a highly interesting piece of writing because it is a strange compilation of the applied aspects of psychological insights. Mr. Wheeler is a direct writer, and he is also an easily read transcriber of ideas in anthology fashion. The contents of this book deal with education, the matter of money and success, the concept of decision, and the keys to success. The author then illustrates his views with some 25 case histories "of people who turned daydreams into success." The book suggests ideas, not necessarily novel ones, but entertaining anyway; it suggests ways and means of making marriage somewhat happier, at least economically speaking; it would have more individuals become leaders in community life by following simple formulas for such success. Perhaps there is a special virtue to such writings; but this reviewer fails to appreciate the "brilliance of the amazing formulas" advocated by Mr. Wheeler.

Psychosurgical Problems. Fred A. Mettler, M. D., Ph.D. (Professor of Anatomy, College of Physicians and Surgeons, Columbia University), editor for the Columbia Greystone Associates, Second Group of 36 Investigators. 357 pages with 56 figures; 4 plates; 57 tables. Cloth. Blakiston. Philadelphia. 1952. Price $7.00.

Psychosurgical problems are brought more clearly into the open by this very thorough study of operated and control groups of schizophrenics. Operative measures included topectomy, venous ligation, thalamotomy, and thermocoagulation. No operative mortality occurred. A chapter on the follow-up of the original Columbia-Greystone patients two years after operation is included.

This method of study included social evaluation, general medical condition; neurological, olfactory and vestibular function and autokinesis; psychologic and psychometric studies; complex mental function; attitude, behavior time sampling; psychophysiological and psychiatric observations.

Thirty-six scientists "asked the questions of nature." As in so many research problems, what one expects and what one finds are two different things. To paraphrase Mettler: "Nature is always talking to us, and to the questions of this study she answered 'No.'" What were the questions?

A most important conclusion is noted on page 310: ". . . Since the continued expenditure of time and effort on conventional lines is not likely to be any more profitable in the future than in the past some effort should at least be made to look for different ways to establish categories to be studied. For example, it might be profitable to group psychiatric patients on their response to some physiologic or psychologic tests or configurations of these, or to employ statistical analysis of rating scales."

One is satisfied by the factual, unbiased observations and conclusions. Although these are objective and "manifest" in nature, no more reliable objective tests were developed in the four years of study to indicate how psychosurgery is effective. The research proceeded with the desire to eliminate the personal ideas and hypotheses of the investigators. Therefore, this text is of real value to all interested in the present techniques and problems of psychosurgery.

Hear and Forgive. By Emyr Humphreys. 249 pages. Cloth. Putnam. New York. 1953. Price $3.00.

This is a boring and practically unreadable book about an English teacher and writer. His conflicts are on the level of complete naïveté. The only amazing thing is that English critics "hailed" the book. It seems that Wilde's statement, "We have everything in common with America, of course, with exception of the language," needs some enlargement.

Helping Older People Enjoy Life. By JAMES H. WOODS. 139 pages. Cloth. Harper. New York. 1953. Price $2.50.

In recognition of generally increasing concern for the aged, the author describes one method of meeting the needs of older people, the story of how Cleveland met the challenge by establishing "Golden Age Clubs," not "Old Age Clubs," to provide for older people an opportunity for further happiness and adjustment.

"This book," the author states, "is written primarily for the volunteer who wants to work with older people in what has come to be called Golden Age Clubs. It is not intended to be a manual on the principles and practices of group work in general. Many persons would like to be of service in this area, but frequently because their acquaintance with older people is limited they are afraid that the venture is beyond their capacities. This book is intended to reassure them and to help them get started."

The text is extremely well written and full of practical suggestions on how to conduct such community projects to bring further happiness and enjoyment to the aged. The book, therefore, should be of great interest to social workers, community agencies and anyone interested in the problem of making happier lives for our older generation.

Mind. A Social Phenomenon. By F. S. A. DORAN. 182 pages. Cloth. Sloane. New York. 1953. Price $3.00.

F. S. A. Doran, author of *Mind: A Social Phenomenon,* is by training a surgeon and anatomist; by inclination he is an adroit philosopher and thinker. Dr. Doran deals most intelligently with the nature of the human mind, its content, its development, and, in conclusion, with patterns of culture as seen through the eyes of the scientist.

There are, according to the author, two distinct groups of opinion about the "nature" of the human mind: One viewpoint is that it is of a non-material, spiritual, even semi-divine and mystical character; and the other viewpoint is that the "mind" is composed of the same kind of "stuff" that goes to make up the physical universe, and that it probably is connected with the function of the brain and the central nervous system. The author also writes brilliantly on the position of the dualists as regards "mind." Thus he undertakes to cover illuminatingly and provocatively the ramifications of the subject.

Mind is a controversial book. It is sound in its arguments, in its examination of contrary opinions, in its conclusion that the human mind is an expression of brain function and that its content is determined by the social force of tradition and by the fears, hopes, prejudices, and values of those with whom we come in contact. And it is more than a controversial book; it is challenging and penetrating and scientific.

Man's Search for Himself. By ROLLO MAY, Ph.D. 281 pages. Cloth. Norton. New York. 1953. Price $3.50.

Rollo May is not the simple psychologist who writes mere self-help books; his *Man's Search for Himself* is a strong, direct, sensible book that deals with intelligence and insight in the anxieties of modern man, the roots of the maladies of our time, man's experiences in living, the goals of integration of personality, the creative conscience, and the virtue of maturity generally. Dr. May rightly realizes, as a clinical and social psychologist, that many people not only do not know what they want in life, they often do not have any clear idea of what they feel in living. He handles well the major inner problems of people in our day. *Man's Search for Himself* prefaces its thesis with the sound statement that "One of the few blessings of living in an age of anxiety is that we are forced to become aware of ourselves." May speculatively develops a basic viewpoint, with his emphasis on finding values and goals that normal men and women can affirm in their day-to-day living.

The roots of our psychological malady, according to Dr. May, are these: the loss of the center of values in our society, the loss of the sense of self, the loss of our language for personal communication, and the loss of the sense of tragedy. What our society needs, then, in the author's opinion, is "not new ideas and inventions, important as these are, and not geniuses and supermen, but persons who can be, that is, persons who have a center of strength within themselves."

Man's Search for Himself is a speculative, philosophic, somewhat therapeutic book, only at times unscientific when the author over-indulges in stringing quotations together. But that is a minor flaw in an otherwise sound volume; and the book deserves high commendation for its lofty message, intelligent approach, scholarly value, and significant understanding of human beings.

The Annual Review of Psychology. Vol. 4. 1953. C. P. Stone, editor. 485 pages. Cloth. Annual Reviews, Inc. Stanford, Calif. 1953. Price $6.00.

This is the fourth volume in its series; it again presents a review of the psychological literature of a year. Most of the various fields of psychology are covered, although the individual articles often seem lacking in detail; and the volume is not complete in coverage of the entire area. The idea behind a text of this type is worthy. However, in view of the numerous fields of psychology, one wonders whether such an undertaking might not be more complete and more valuable if there were separate volumes for each of the major areas of psychology.

Phantasy in Childhood. By AUDREY DAVIDSON and JUDITH FAY. 188 pages. Cloth. Philosophical Library. New York. 1953. Price $4.75.

This is an interesting and informative book on the development of fantasy in children. Written by two British women, one an analyst (Davidson) and the other a Froebel teacher and former writer (Fay) who has worked with individual psychotic children, the authors are of the Melanie Klein school and present their material from that viewpoint. The chapters progress roughly in the order of psychosexual stages, going from the oral stage through the latency period. The pattern of the book is the constant interweaving of theoretical material with concrete examples from individual cases. The last chapter "The Living-Through of Phantasies" presents, in detail, a single case. The book is well written and brings in many examples of fantasy from the field of children's literature. Although the authors state they have written in non-technical language, this is not a book for a lay audience, since it assumes familiarity with a considerable amount of theory. A practical aspect of the book is that much of the material has mental hygiene significance, and it should be valuable from that point of view as well as from the theoretical standpoint.

The Art of Human Relations. By HENRY CLAY LINDGREN. 287 pages. Cloth. Hermitage House. New York. 1953. Price $3.50.

"The writing of this book," the author states, "was based on the premise that growth in the direction of emotional security may be added if we improve our understanding of ourselves and the people in our lives, particularly if we gain a better understanding of the relations between ourselves and others."

Most of the text material reflects the author's own experiences and insights gained from the theories and formulations of such workers as Harry Stack Sullivan, Patrick Mullahy, Clara Thompson, Karen Horney, and Erich Fromm. The text is simply written in understandable terms. It helps the reader to recognize and identify certain feelings and experiences, and to see ways in which they are interrelated.

Derricks. By JAMES BARR. 250 pages. Cloth. Greenberg. New York. 1951. Price $2.50.

This is a collection of seven short stories about homosexuals, written in the by now familiar form of whining and naïveté. Not the slightest attempt is made at psychological explanation: "A man likes men that way or he doesn't, and that's all there is to it [p. 220]." Unfortunately, that's not all there is to it, and a good writer goes after the unconscious factors. As psychological novels, the present tales are just as unsatisfactory as the author's previous book, ***Quatrefoil,*** against which the identical objections were expressed in this QUARTERLY.

Psycho-Analysis and Child Psychiatry. By EDWARD GLOVER, M. D. 42 pages. Paper. Imago. London. 1953. Price 6/—.

In this brief, concise, and orderly monograph Dr. Glover has attempted a psychoanalytic explanation of childhood disorders, reaching back to infancy. Utilizing the psychosexual theory of development, and various attendant concepts of adaptive mechanisms, i. e., regression, projection, fixation, etc., he attempts to demonstrate how the organization of the ego and super-ego evolves from the amorphous collection of "instincts," sensations and impulses of early infancy. He sketchily considers how neurotic, pre-psychotic and psychotic patterns of behavior grow out of and are manifested at the various developmental levels, stating that two main groups of behavior may be distinguished: (1) "disturbances of functioning and development" and (2) "symptom-formation which in some respects resembles the psychopathological states observed in adults." However, it is questionable whether a diagnosis of psychosis can safely be made in the case of the three-year-old child the author cites. Not only is his evidence weak, derived from an analysis of the child, but it is also lacking in corroborative data from psychology. He discusses briefly the application of analytical treatment to childhood and infant disorders, including the basic free-association technique. But one feels that more fundamental in his treatment is the "rapport situation," typical of "non-directive" therapies, rather than analysis *per se*.

As with much analytical literature, some semantic confusion occurs, i. e., mention of "instinctual objects" and "instinctual experience." However, Dr. Glover is to be praised for his assertion "that psychoanalysts can no longer claim total exemption from the customary scientific controls . . . and must submit their observations to the most rigid statistical control." In all, this is a thoughtful and thought-provoking study which is to be recommended to those interested in an analytical approach to child psychiatry.

The Sex Paradox. By ISABEL DRUMMOND. 362 pages. Cloth. Putnam. New York. 1953. Price $5.00.

Isabel Drummond compiles data on the different treatments of sex-offenders in different states, giving informative material on penalties imposed. The subtitle of the book, "An Analytical Survey of Sex and the Law in the United States Today," is a misnomer; the book is not an analytic one in the technical sense; the term is used in popular connotation. The author, a Philadelphia lawyer, is skeptical of the penal results, and conflicting theories; she advocates further study. It is regrettable for the scope of the book that her knowledge of the newer psychiatric-analytic literature on criminology is rather restricted and limited.

Cerebral Mechanisms in Behavior. Hixon Symposium. Lloyd A. Jeffress, editor. XIV and 311 pages with 45 figures and 3 tables. Cloth. Wiley. New York. Chapman and Hall, Ltd. London. 1951. Price $6.50.

Six major papers and the discussions of 18 participants in the Hixon Symposium on "Cerebral Mechanism in Behavior" bring a very complicated subject into closer focus. Many thinkers and clinicians may find their own unexpressed problems and questions formulated in words, ideas, or theories, with some experimental evidence for and against them. The symposium has the typical effect on the reader, in that more facts and questions are propounded and under scrutiny than if he had merely listened to the major speakers. Sometimes too much is stated in a few sentences. Pet theories are pretty well clarified and "brought down to size."

The immense field involved in the discussions was viewed by recognized men in the fields of chemistry, electronics, mathematics, physiology, zoology, psychology, psychobiology, psychiatry, neurology, and philosophy.

Neuman, in his theory of automata (related to the field of cybernetics), conceives how machines can repair or "reproduce" themselves. de No and Weiss point out that machines are artificially made and by their limitations are precise and predictable while the human brain is more subject to error, is non-rational, and has memory. Lashley discusses the problem of "Serial Order in Behavior," covering the chain theory, mechanism of integration and speech. Kleever shows the functional differences between occipital and temporal lobes. In his discussion, Nielson reports further studies in agnosia. Kohler discusses the "Relational Determination in Perception." Halstead brings intelligence under discussion; McCulloch integrates brain anatomy and physiology; Brosin looks at the symposium from the clinical side. A short name and subject index is presented.

This text is recommended for repeated reading.

The Life and Times of Sir Edwin Chadwick. By S. E. Finer. 555 pages. Cloth. British Book Centre. New York. 1952. Price $7.50.

One of the outstanding crusaders in public health in Nineteenth Century England was Sir Edwin Chadwick. Despite the fact that the *immediate* concrete results of his work were negligible, the long-term effects are hard to overestimate. This biography is designed for the student rather than for the general reader—attention to his private life has been subordinated to a review of his public career—but at the same time the author has managed to make what could have been an exceedingly dull chronicle surprisingly interesting in spots.

The Making of a Scientist. By ANNE ROE, Ph.D. 244 pages. Cloth. Dodd, Mead. New York. 1953. Price $3.75.

The Making of a Scientist is a well-known clinical psychologist's account of a pioneer research project designed to investigate the relationship between personality and vocational choice. The writer—working under the assumption that certain personality factors related to vocational choice would be present and possibly most evident in the men most successful at their vocations—selected 64 of the foremost American research scientists from the fields of the biological, physical and social sciences. Others were also studied so as to determine how closely the eminent men in each field resembled the majority of scientists in that field.

Although by no means definitive or conclusive, Anne Roe's book does leave one with some understanding of the kind of person the scientist is and why and how he became a scientist. However, this is not a technical report, but rather an endeavor to communicate some highly interesting findings to scientists and society in general. The psychologist reading this book will, therefore, find the data presented too insufficient to permit a critical evaluation of the generalizations and interpretations made by the author.

The Mentally Retarded Child. A Guide for Parents. By ABRAHAM LEVINSON, M. D. 190 pages. Cloth. John Day. New York. 1952. Price $2.75.

A noted pediatrician writes with sympathy about the various aspects of mental retardation. He states from a medical point of view, not only facts that parents should know, but the important aspects of the education and management of the retarded child.

He offers parents hope and encouragement without misleading them into false optimism or ways of effecting "cure." Dr. Levinson feels that in almost every case something can be done to improve the child, and he outlines treatment.

Specialists in the field will be interested in a list of selected readings and—for counseling parents—a list of schools, both public and private, for retarded children.

The Cup of Trembling. By KARL BROWN. 312 pages. Cloth. Duell, Sloan & Pearce. New York. 1953. Price $4.00.

The Cup of Trembling is a historical novel, centering around Harriet Beecher Stowe's unloved son, Fred. Nothing is known about the real Fred, except that the author of *Uncle Tom's Cabin* behaved peculiarly toward him. When he was seriously wounded at Gettysburg, she ignored even that fact. The author makes out of his hero a rebel against his mother's convictions, blaming her in part for the Civil War. Some historical details, and the family story of the famous woman are interesting.

Psychosomatic Research. By Roy R. Grinker, M. D. 208 pages. Cloth. Norton. New York. 1953. Price $3.50.

Recent years have seen a deluge of studies and hypotheses reaching print under the general term of "psychosomatic." For the most part, little attempt has been made to define "psychosomatic" carefully, and to systematize the broad and diverse formulations and methodologies which have appeared. The object of this book is to present a critical approach and evaluation of contemporary work and to attempt to formulate a comprehensive theoretical framework as a basis for future research.

It is Grinker's belief that past psychosomatic research has gone astray through too intense an interest in the correlation of specific emotional states with specific somatic systems, and "has led to the premature spreading of tentative hypotheses."

"Psychosomatic" means more than a kind of illness. It is a comprehensive approach to the totality of a process that takes in many systems: somatic, psychic, social and cultural. Grinker states that research must take two approaches; (1) "a study of maturation and differentiation of psychosomatic processes" and (2) "the use of multidisciplinary (the medical, biological and social sciences), simultaneous and prolonged observations of many phases of. . . psychosomatic processes." He considers his theoretical framework to be holistic in nature—a field theory. The field ranges from the "enzymatic system" to the "socio-cultural system." Not just the nature of somatic functions, or psychological processes, should be studied. Rather, "all the forces contributing to psychosomatic unity, development, differentiation and unhealthy disintegration" are the proper area of investigation.

Dr. Grinker presents a brief and concise history of psychosomatic concepts and an exposition and evaluation of the hypotheses of the major workers in the field today—with a specific review of the "structure and function of the mouth" followed by a discussion of the "psychological implications of oral functions." An extensive bibliography of source material is provided.

This is an excellent summary of contemporary work in psychosomatic medicine and an important outline of a theoretical framework which could well be the basis for much constructive research in the future.

Stephania. By Ilona Karmel. 375 pages. Cloth. Houghton-Mifflin. Boston. 1953. Price $3.75.

Stephania is a bitter and meaningless book about three women in a Swedish hospital. The author, a protegé of Archibald MacLeish, has a tragic life of Nazi persecution and concentration camp behind her. She is entitled to sympathy; but as a writer, she confuses bitterness with literary aims.

Understanding Stuttering. By A. B. Gottlober, Ph.D. 274 pages. Cloth. Grune & Stratton. New York. 1953. Price $5.50.

With over 1,300,000 stutterers and stammerers in the United States, this book is important emphasis upon the need to understand and remedy a speech handicap which affects the individual's adjustment throughout life. The author defines stuttering and stammering as "blocking," i. e., a functional disorder. It has its roots in a reaction against "anxiety producing situations and develops through conditioning." The individual "will not recover unless he can learn to cope successfully with anxiety producing situations." The "blocking" process may be "reversed" through the early application of treatment which involves: education into the nature of speech difficulties, reconditioning of speech patterns, relaxation and psychotherapy. A detailed discussion of each phase is provided by the author.

The author correctly emphasizes that "blocking" is a function of the whole organism, not of the speech apparatus alone, and that "not the pattern of speech, but his pattern of living is our prime concern and should be his." This "first-aid manual for stutterers," written in a simplified, consulting-room style, is addressed primarily to a lay audience, but is urged upon physicians and social service professions as a valuable guide.

A brief and elementary discussion of the neurophysiological basis of speech production—with illustrations—is provided.

The Power Within. By Sir Alexander Cannon. 208 pages. Cloth. New York. 1953. Price $3.00.

The author has traveled to many corners of the earth seeking reliable instances of occult phenomena. He reports that he has demonstrated many of his findings in his own laboratories.

"The purpose of this book," it is stated, "is to make the reader master of himself, and a source of good in the world, to bring happiness and peace to mankind, above all, to acquire a sound knowledge of the conscious, subconscious and unconscious states of mind and how they work; for to know mind is to know God."

The discussion seems to be based on mystic Oriental concepts. It includes in this framework discussions of sleep and dream states, levels of consciousness, instinct, emotions, and mental processes. There is a chapter dealing with abnormal states of mind which covers almost all clinical entities. The author's viewpoint aside, he adds supporting evidence to the view that clairvoyance, telepathy and similar phenomena call for serious scientific consideration.

Proceedings of the Second Research Conference on Psychosurgery. Public Health Service Publication No. 156. Winfred Overholser, M. D., editor. 116 pages. Paper. Federal Security Agency. National Institutes of Health. U. S. Government Printing Office. Washington, D. C. 1952. Price 75 cents.

The research conferences on psychosurgery draw in a wide variety of fields, from the nation's specialists who deal with the psychosurgical patient or the potential patient for psychosurgery.

The second conference, presided over like the first by Fred A. Mettler, M. D., covered in particular the classification of patients and the practical and theoretical considerations involved in hospitalization and treatment. The questions of affectivity, deterioration and creativity were presented and discussed exhaustively. Robert A. Cleghorn, M. D., led the discussion of "Base Line Data and Psychiatric Categories"; Hester B. Crutcher discussed "Evaluating the Environmental Situation of the Mentally Ill Patient" and Robert G. Heath, M. D., presented an "Analysis of Schizophrenia." The much-discussed matter of creativity in psychosurgery patients was presented by Joseph Zubin, Ph.D. An appendix to the report gives the "Descriptive Scales for Rating Currently Discernible Psychopathology" by J. R. Whittenborn, Ph.D.

Like the first research conference report, this small volume is essential background material for all administrators and clinicians dealing with psychosurgery.

Afraid in the Dark. By MARK DERBY. 280 pages. Cloth. Viking. New York. 1952. Price $3.00.

Here is a British thriller, making full use of the improbable: a search for a Malayan sadist who tortured women in a Japanese concentration camp, a search conducted without benefit of the authorities, and executed by a neurotic ex-captain, paid by the husband of one of the victims. The technique of the narrative is routine; the author passes up an opportunity to explain the psychology of sadism. Of course, Mr. Derby does not consider carrying out such an unorthodox idea.

The Intimate Life. Or the Christian's Sex-Life. By NORVAL GELDENHUYS, B. A., B. D., Th. M. 96 pages. Cloth. Philosophical Library. New York. 1952. Price $2.75.

The author states that this is an abridged portion of his book, *Marriage*. It discusses intimate facts and principles of pre-marital and of marital life. It frankly and explicitly describes the moral and spiritual issues involved. It is the type of book which priests and ministers could safely recommend.

Medicine. Volumes I and II. Hugh G. Garland, M. D., and William Phillips, M. D., editors. 2,146 pages including index. Cloth. St. Martin's Press. New York. 1953. Price $25.00.

This is an extraordinarily comprehensive British system of medicine. It is a compendium of the work of 42 distinguished authorities, 40 of them now practising or teaching in Great Britain or Ireland and the other two elsewhere in the British Commonwealth of Nations. It is splendidly illustrated, beautifully printed and well bound. It is, in fact, an excellent example of the best type of British scientific text. The American physician will find it of unusual interest as covering adequately, and with no apparent bias, problems of social medicine and public health. There are 167 pages of "art plates," seven in color, besides numerous halftone and line illustrations throughout the text.

The two volumes cover the whole medical field, dividing it into 40 sections. These include treatment of such matters as genetic factors in disease; nutrition; industrial diseases; aviation medicine; and such tropical diseases as are important in temperate zones. Psychiatric and neurologic disorders are treated entirely separately and are not even in the same volume. The discussion of psychosomatic medicine, the psychoneuroses and psychoses would meet with general American approval.

Unfortunately for the purposes of a great over-all picture, however, discussion by individual specialists is bound to be authoritative on matters about which there is no general unanimity of opinion. For example, David N. Parfitt, M. D., who is consultant psychiatrist and medical superintendent of Holloway Sanatorium, Virginia Water, Surrey, is the author of the chapters on the psychoneuroses and the psychoses. He is ambivalent, to say the least, about masturbation: "Where the habit is associated with much mental disturbance it is merely a symptom of a more serious nervous illness. . . ." And: ". . . In the long-term interests of character formation it is better controlled." As for psychoanalysis, which is discussed under treatment of the psychoneuroses, Parfitt says: "Psychoanalysis should be avoided until other methods have been given adequate trial. Not only is the treatment excessively prolonged—it may stretch into years—but about half of the patients analysed fail to improve and some few are made worse." Parfitt does, however, find conditions in which analysis is indicated.

The reviewer has no wish to carp about this sort of thing. *Medicine* is not a general physician's guide to practice but a text for medical teaching. Any specialist can disagree with conclusions reached in almost any such text but the latter can be a splendid basis for instruction nevertheless. American medical readers should find these volumes, not only an excellent teaching instrument, but a splendid and often-consulted addition to any institution or personal medical library.

Psychiatric Dictionary. Second edition with Supplement. By LELAND E. HINSIE, M. D., and JACOB SHATZKY, Ph.D. 781 pages. Cloth. Oxford University Press. New York. 1953. Price $15.00.

Drs. Hinsie and Shatzky have brought out an enlarged second edition of their invaluable psychiatric dictionary, first published in 1940. Compiled by the assistant director and the research librarian of the New York State Psychiatric Institute, with the aid of a strong group of specialist-collaborators, their first edition has been, not only a standard, but an indispensable, reference work. The definitions of this dictionary are encyclopedic, with much quotation from standard authors.

While such a dictionary as Dr. Richard H. Hutchings' *Psychiatric Word Book* is more compact and is thus handier and easier to use as a student's pocket volume or a practitioner's desk reference, Hinsie and Shatzky's book gives original meanings, shades of meanings and terms no longer current, which cannot be included in a handbook but are of great importance for the scholar.

The form of the new edition is enlarged by a supplement covering some 900 terms and concepts which are either new or were overlooked when the original dictionary was compiled. This supplement covers 218 pages of the new volume. It has the drawback, of course, of compelling the user of the dictionary to check two separate vocabularies for definitions. This form also means that the original body of definitions has been picked up for re-publication without change. Some modifications that the captious might find desirable could not, therefore, be made. There are several instances, for example, of the use of the term "insanity"—not under the main definition but in other references—without noting the present generally observed restriction to a legal sense. The method of binding a supplement into the new edition, however, has an important advantage. The original plates can be used for the greater part of the book, and the cost thus kept within reasonable limits.

Anatomy of the Nervous System. Ninth edition. By STEPHEN WALTER RANSON, M. D. Revised by Sam Lillard Clark, M. D. 581 pages. Cloth. Saunders. Philadelphia. 1953. Price $8.50.

The ninth edition of this standard text and reference volume has been materially enlarged and revised since the eighth edition was published in 1947. "Significant advances in neuroanatomy and neurophysiology," says Dr. Clark in the preface, "have been made in many directions and by recent investigators from various disciplines. . . . It is hoped that the incorporation of new material and illustrations and the re-writing of many portions of the text in this revision will make it more usable." Besides revision and enlargement of the text, both bibliography and index items have been increased, adding materially to the value of the volume.

Contributions Toward Medical Psychology. Volumes I and II. Arthur Weider, editor. 885 pages including index. Cloth. Ronald Press. New York. 1953. Price $12.00.

The title of this book should be read in the current American rather than the old-fashioned sense. Weider's "medical psychology" is not psychiatry, but is the collection of psychological procedures employed by the clinical psychologist and/or the psychiatrist for the estimation of mental states. His review covers material presented by specialists in widely varying fields of human development. For instance, the authors on the Rorschach techniques are Beck, Munroe, Harrower and Kellman. Gesell covers human infancy and the embryology of behavior. Kluckhohn and Mowrer are the discussants respectively of "Determinants and Components of Personality" and "What is Normal Behavior?" Franz Alexander writes on the psychological aspects of medicine.

Volume I of this compilation covers the general subjects of "Psychology and Medicine," "Some Aspects of Psychology" and "Psychosomatic Relationships." Volume II, Part IV of the collected work, is devoted to psychodiagnostic methods and medical practice.

The whole work is a comprehensive and important reference volume for teaching and general use. Its value to the psychologist is self-evident. In addition, this reviewer thinks it belongs in every medical library where psychiatric and psychological references are likely to be needed. It should be invaluable to the medical practitioner or administrator who needs "refresher" information on psychological subjects, or who needs to know just what the psychologist can be expected to do for him in the course of medical administration or medical practice.

The Loves of Florizel. By PHILIP LINDSAY. 208 pages. Cloth. Roy Publishers. New York. 1952. Price $3.50.

George IV was brought up in the rigorously puritanical family of that unfortunate psychotic, George III. He was personally unattractive as a child; he was educated by harsh tutors; he appears to have had little love from his parents. His subsequent career as a royal debauchée could be explained simply as a reaction to this unroyal bringing up. He was a boor, a drunk and a he-trollop. Philip Lindsay has written a readable, light, and, on the whole, entertaining story of the king's excursions from drink to women and back to drink again. Lindsay writes for the general reader. His story of England's certainly most idle, and possibly most disliked king, is not a psychiatric study, but it includes the material from which one may well judge a character organization and its origins.

The Devil Rides Outside. By JOHN H. GRIFFIN. 596 pages. Cloth. Smith's Inc. Fort Worth. 1952. Price $4.00.

Here is a strange book about a young American musicologist whose studies lead him to spend some months in a French monastery. The hero is completely out of focus; neither his strange adventures, nor his obsession with chastity, nor his attraction for mystical problems are explained. On the other hand, besides adolescent writing, are some glimpses of future possibilities. Some of the monks, and a middle-aged woman, Mme. Renée, are interestingly described. The book is nearly 600 pages long; most of it is difficult to take; one expects the story of a conversion, but nothing happens.

Women. A. M. Krich, editor. 311 pages. Paper. Dell. New York. 1953. Price 35 cents.

This is an incongruous compilation of excerpts from such authors as Havelock Ellis, Helene Deutsch, and Therese Benedek, mingled with dubious statements on frigidity by the anthropologist, Margaret Mead, and ending with a worthless paper of O. Schwarz on love. It is problematical whether such compilations make sense.

Marriage, Morals and Sex in America. By SIDNEY DITZION. 440 pages including index. Cloth. Bookman Associates. New York. 1953. Price $4.50.

Sidney Ditzion has compiled a not-too-pedestrian review of marriage and sex morality in America from colonial times to Kinsey. It is a tremendous collection of the significant and the trivial.

The reviewer thinks it an excellent work for any student of social science but believes it covers too much territory for accuracy in detail. It is, however, the handiest reference he has seen on this particular subject and is to be recommended—with the reservation that it should not be accepted as a primary source—for general reading and library use.

Language and Myth. By ERNST CASSIRER. 103 pages including index. Dover Publications. New York. 1946. Price (paper), $1.25; (cloth) $2.25.

The scientist who is concerned with the private language and the private mythology of the deranged individual must view his findings against the backdrop of word and myth of early mankind. Professor Cassirer was an internationally renowned authority on the phenomena of myths and their history, and on the phenomena of language development. This very short volume is an introduction to his findings and philosophy. This volume is well designed and is clearly printed on good paper. A paper-bound edition for students sells at $1.25, about half the price of the regular edition.

Elementary Statistics with Applications in Medicine. By FREDERICK E. CROXTON, Ph.D. 376 pages including index. Cloth. Prentice-Hall. New York. 1953. Price $7.50.

It would be difficult to exaggerate the need for such a book as this in the strictly medical field. The poor handling of statistics presents a problem familiar to anybody who handles medical manuscripts. Professor Croxton says: "Although this book deals with elementary statistical methods, it is hoped that it will be widely useful to workers in the medical and allied fields. No previous study of statistics is assumed, and only a very modest knowledge of mathematics is required."

The reviewer thinks this is an understatement. It is true that the author has exercised the greatest care to explain his statistical procedure point by point and symbol by symbol. It is also true that he has gone to the greatest pains to give mathematical backgrounds, derivations and rationales of common, standard statistical procedures. He does not, however, chart any royal road to statistics. The understanding and application of his methods will be difficult for anybody who has not had a considerable grounding in mathematics. They should not, however, be impossible.

The book covers: rates, ratios and percentages; tabular and graphic presentations; frequency distribution; measures of central tendency; dispersions, skewness and kurtosis; linear correlation of two variables; nonlinear and multiple correlation; the normal curve; the reliability and significance of arithmetical means and of proportions; the Chi square test; significance tests for variances and tests for correlation coefficients. There are 14 appendices of various data for use in scientific statistical work, ranging from ordinates of the normal curve to tables of squares, square roots and reciprocals and a table of logarithms.

In this reviewer's opinion, this book should be in the hands of everybody who is reporting, or is likely to report, scientific material. He feels there is particular need for such a reference and guide in the fields of psychiatry and psychology where statistical methods are all too often far from professional.

Cradle of the Sun. By JOHN CLAGETT. 304 pages. Cloth. Crown. New York. 1952. Price $3.00.

Clagett writes of a tragic period in history, the downfall of the Maya peoples before the Spanish conqueror. There is in the fact of the conquest and in the psychology of the conquerors and the conquered a setting for a tale of major tragedy with its psychological foundations. Clagett has attempted no such thing. He has not written a tragedy; he has not even written a psychological story; but he has written a grand adventure tale, seemingly faithful to its social and historical background—and this was doubtless all he intended.

King Turd. By ALFRED JARRY. Translated by Beverley Keith and G. Legman. 189 pages. Cloth. Boar's Head Books. New York. 1953. Price $4.00.

Whether one credits the story that Alfred Jarry composed his anal masterpiece *King Turd* as a schoolboy satire does not really matter. It could have been written by a boy of 14 whose ideas of revolt were circumscribed by the "dirty words" scrawled on public toilet walls.

King Turd, a play whose production scandalized Paris in 1896 when its author was 23, is the drama of a human race fit only to be thrown down the privy. If it is childish, so were Gulliver's Yahoos who climbed trees to throw feces at passersby. The author was as mentally disordered a person as any who ever achieved literary notoriety. His masterpiece could serve as a psychiatric text on the anal erotic stage of emotional development. King Turd is exactly what his title implies. All the other characters inhabit the latrine. Their language is latrine language. There is nevertheless a certain light-hearted abandon in Jarry's scatological sadism. Humans are feces, says he, but who cares?

The reviewer fears this translation is likely to be dismissed as a piece of purposeless scatology. He thinks, on the contrary, that it is a most interesting human document, well worth reading by anybody concerned with the dynamics of the mind. And, oddly, if one can be emotionally mature about the scatology and the cruelty involved, it is not without a certain, perhaps childish, entertainment value besides.

An Introduction to Projective Techniques. Harold H. and Gladys L. Anderson, editors. 720 pages including index. Cloth. Prentice-Hall. New York. 1951. Price $6.75.

The Andersons have compiled a basic volume—which is winning increasingly high regard—on the projective techniques which are the basis of much modern psychiatric diagnosis and clinical psychology. The contributing authors are widely known and are, for the most part, recognized authorities. The book covers, often in enough detail for emergency use as a manual for administration, such techniques as the Rorschach, the TAT, word association and sentence completion tests, the Bender Visual Motor Gestalt, human figure drawing, fingerpainting, graphology and the Szondi test. A section of general intelligence tests, as used for personality appraisal, takes up the Wechsler-Bellevue and the Stanford-Binet. Another section covers therapeutic uses of puppetry, play and psychodrama. This book is a useful desk reference for any psychologist or student of psychology and it should be of even wider use for the psychiatrist who wishes to look up the application or the possibilities of specific psychological techniques.

The Natural Superiority of Women. By ASHLEY MONTAGU. 194 pages. Cloth. Macmillan. New York. 1952. Price $3.50.

Ashley Montagu is one of the most socially useful of our social scientists. His work for UNESCO and elsewhere in combating race prejudice, for example, has been widely recognized by psychiatrists as well as anthropologists.

In the present book Professor Montagu has let his overflowing good will overflow too far. Men and women are different, as most children are aware, and as the continuing growth of population testifies. Professor Montagu itemizes the differences, known and not so well known, physical and emotional and/or mental. He concludes that women are the superior sex and that the hope of mankind is in women. "Maternal love is the purest and at the same time the most efficient form of love because it is the most compassionate, because it is the most sympathetic, because it is the most understanding and the least censorious." Distortion of this emotion is also productive, this reviewer would note, of "Momism."

Some of Professor Montagu's data are doubtful; a great many of his interpretations are more than doubtful; and many of his conclusions are *non sequiturs*. It is probably general psychiatric opinion, founded on sound research and long clinical experience, that men and women are necessarily complements of each other. There is no sound medical or psychological evidence of which this reviewer is aware to lead to the conclusion that, because they are different, one is superior to the other.

This reviewer begs to doubt also whether there is a sound social reason. Women have long suffered from the self-arrogation of the male to a position of false superiority. We see no good reason now to reverse the process. Speaking as a scientist, Bertrand Russell recently wrote in *The Impact of Science on Society*: "If you say that the rich are abler than the poor, or men than women, or white men than black men, . . . you proclaim a doctrine . . . which is almost certain to lead to either slavery or war." One could just as well read here Professor Montagu's suggestion that women are abler than men. This reviewer thinks the balance of science and of sound political thinking is on the side of Russell.

Fool's Haven. By C. C. CAWLEY. 210 pages. Cloth. House of Edinboro. New York. 1953. Price $2.75.

The author of this novel evidently aimed at a crusading volume against the variety of faith-healing which inflicts death on the innocent rather than call on medicine. The idea is excellent, the characters lifeless, the plot implausible; and the whole conclusion misses its objective by several light years. This is a pity, because it is all to the good of mental hygiene to promote wider interest in this subject.

The Palm-Wine Drinkard. By Amos Tutuola. 130 pages. Cloth. Grove Press. New York. 1953. Price $2.75.

This is a fascinating tale by a native West African writer whose English is his personal achievement and whose hero would, by any western standards, be considered an at least amoral psychopath.

The palm-wine drinkard, like Dante, visits the land of the dead. He performs magic; he meets a Skull who seems to be a "beautiful 'complete' gentleman" with a fatal fascination for ladies; he lives in a white tree and flies through the air with the aid of his juju. But this is no artlessly primitive tale. The drinkard carries a gun, trades with British money, sits in judgment in a court with a travesty of English rules and compares his juju-flight through the air with a plane trip. He also meets a crowd of dead babies, is sheltered inside the tree trunk by a "faithful-mother," finds an egg which feeds the world, is swallowed and regurgitated by a fearful "hungry-creature" and finally sends a slave "to heaven" in what seems to be human sacrifice.

This book is a serious one; the West African society it concerns would certainly recognize it as fantasy, but as appropriate fantasy; it is simply based on concepts and told in language which are not of our world. If a gifted western writer could present a hallucinatory tale in pure art, we might have something like this.

Mr. Cantonwine. By Lionel Barrymore. 218 pages. Cloth. Little, Brown. Boston. 1953. Price $3.00.

The purpose of Lionel Barrymore's "moral tale" is a bit difficult to come by, unless it is to illustrate in the language and ideas of a century long gone the fact that a harlot's life is not a happy one. Barrymore's story involves an unsophisticated but selfish young lady who runs off with the villain; an itinerant preacher; a captive bear; a talking crow; and an anachronism or historical distortion or two which a well-disposed reviewer can only suppose to be deliberate. There is, however, something entertaining in this artless hodge-podge and maybe even something profitable enough to repay the reading.

The Face and Mind of Ireland. By Arland Ussher. 191 pages including appendix. Cloth. Devin-Adair. New York. 1950. Price $2.75.

Ussher's book has had wide critical acclaim, more in literary and philosophical than in sociological or psychological circles. It is, however, a brilliant picture of the surface social psychology of one of our most ancient cultures and newest nations. Any person who would understand Ireland or Ireland's children in the United States—including those children themselves—cannot but be the richer for its reading.

Hope for the Troubled. By LUCY FREEMAN. 256 pages including index. Cloth. Crown. New York. 1953. Price $3.00.

Lucy Freeman, who writes much on psychiatry and mental hygiene for the *New York Times*, and who is the author of an account of her own psychoanalysis, *Fight Against Fears*, presents in *Hope for the Troubled* the best general discussion this reviewer has yet seen of where the mentally distraught may go for aid and of what kind of help they may expect to find there. She discusses briefly the genesis of mental disorder, the development of scientific resources for its amelioration and the help that can be afforded by counselor, psychologist and psychiatrist.

"The deepest form of help available to the troubled," she notes, "is psychoanalysis." Miss Freeman devotes a couple of excellent chapters to an adequate discussion of the unpleasant fact that psychiatric difficulties are too often mistaken for physical. She discusses hospitals and treatment methods. As a person greatly benefited herself by psychoanalysis, she is, understandably, less than enthusiastic about psychosurgery and shock, but she is no fanatic. A chapter of this book is very usefully devoted to the quack therapies from astrology to "Yoga." She is firm in her belief that the troubled can find help; and her book is an excellent guide for those who need it.

Besides the text, there is an appendix listing state mental health associations, federal agencies, national professional organizations and counseling agencies.

The Life-Giving Myth. By A. M. HOCART. 252 pages including index. Cloth. Grove Press. New York. 1953. Price $4.00.

The Life-Giving Myth is a short collection of essays, notes and brief discussions by a distinguished anthropologist whose papers were collected and edited after his death. In the introduction, Lord Raglan notes: "Myth, ritual and social organization are inseparably connected and cannot profitably be studied apart." To these, this reviewer thinks, should be added personality organization.

Hocart's volume is of basic worth to people interested in the fundamental correspondences between the mythology of the race and the personal mythology of mental aberration.

Tomorrow the Harvest. By VIOLA PARADISE. 316 pages. Cloth. Morrow. New York. Price $3.50.

An unfortunate book transforms an interesting setting into boredom personified. Setting: Maine in Revolutionary days. End effect: The book is barely readable.

More Clinical Sonnets. By MERRILL MOORE. 72 pages. Cloth. Twayne Publishers. New York. 1953. Price $3.00.

Merrill Moore is an eminent psychoanalyst who finds outlet for some of the impulses that too many of us repress in what his publishers call Freudulent verses. Dr. Moore's idea of what constitutes a sonnet is somewhat elastic; he will never receive a literary prize from the traditionalists, but his work is smooth, is sophisticated and is excellent versification. His source, of course, is in the great mine of his patients' unconscious and his own. Subjects of his latest little volume range from a "dodunk" whose enemies had a term for him that would bar a less responsible author from the mails, to the need for psychiatrists. Says he:

"There is no shortage of psychiatrists—
There are enough in spite of what some tell
To cure the patients who really want to get well."

The psychiatrist who, as all good psychiatrists should, has retained his sense of humor, will find this volume delightful, as will the more sophisticated of his friends and patients.

Trial of Peter Griffiths. George Godwin, editor. 219 pages. Cloth. British Book Centre. New York. 1950. Price $3.50.

Peter Griffiths was a sexual psychopath who raped and murdered a child, was tried for it, convicted and sentenced to death. His trial is of considerable interest to psychiatry because of its modern (1948) application of the M'Naghten rules in a British court, and because of the conflicting testimony of the medical experts, and the study appended to the trial record, "Schizophrenia and Other Mental Disorders of Medical-legal Import" by C. Standford Read, M. D., consulting psychiatrist to the West End Hospital for Nervous Diseases. The charge to the jury, in which Mr. Justice Oliver summarizes the medical evidence and discusses whether this or that matter of the defendant's conduct is consistent with schizophrenia, is particularly worthy of attention.

Trial of Peter Griffiths is Volume 73 of the expertly edited and well presented *Notable British Trial Series*. It is of considerably more psychiatric interest than are most of those volumes.

Cast the First Stone. By CHESTER HIMES. 346 pages. Cloth. Coward-McCann. New York. 1952. Price $3.75.

In a novel on prison life, the factuality of the incidents cannot be checked by an outsider; but the psychological elaboration—unconscious masochistic provocations and homosexuality—can. Both are wrongly described; not the slightest inkling of the true unconscious meaning of criminosis can be detected. Paradigmatic is the fact that clear-cut unconscious provocations for the purpose of libidinized punishment are described as "temper."

Science and Human Behavior. By B. F. SKINNER. 461 pages. Cloth. Macmillan. New York. 1953. Price $4.00.

B. F. Skinner is an eminent psychologist of the behaviorist school who is best known for his development of a system of behavior that is based upon his observation of animal behavior in a type of experiment which he developed. The theories and experiments related to this system were summarized and presented, without more than the most casual references to human behavior, in his *The Behavior of Organisms* (1938). His present work, *Science and Human Behavior*, is an attempt to extend his system into the field of humanity.

In this book, Dr. Skinner contends that "behavior is a lawful scientific datum" which can be predicted and controlled with the same kinds of lawfulness that apply generally to the natural sciences. Working on this assumption, he attempts to present a direct, scientific analysis of the conditions and influences determining behavior in an effort to reveal the rules that govern it and to acquire a comprehensive picture of the human organism as a behaving system. Once having evolved common formulations of the behavior of the individual, the author discusses the issues relative to man's social behavior and social environment, as well as the special problem of the control of human behavior as it applies to the fields of government, religion, psychotherapy, economics and education.

Skinner's book represents a commendable attempt to apply the scientific method in the development of an original and comprehensive system of behavior theory. It is highly recommended to those interested in the scientific approach to this problem.

Two Essays on Analytical Psychology. By C. G. JUNG. Volume 7 of the Collected Works. x and 329 pages. Cloth. Pantheon. New York. 1953. Price $3.75.

These essays, on "The Psychology of the Unconscious" and "The Relations Between the Ego and the Unconscious" are important subsidiary works that help formulate the Jungian theories. Students of the development of the various psychological schools will find this book of great value, because the editors have included, not only the essays as finally revised by Jung, but also the original papers from which they are derived. The later revisions of these essays have been of two types: needed amplifications and expansions of the original and also the working in of Jung's own present theories concerning the collective unconscious.

The criticisms expressed in this book of both Freud and Adler, and the comparisons between them, are interesting and comprehensibly written. This reviewer found much more difficulty in following the author when he propounded his own theories.

Hypnotherapy in Clinical Psychiatry. By HAROLD ROSEN, Ph.D., M. D. XII and 313 pages including references and index. Cloth. Julian Press. New York. 1953. Price $5.00.

Dr. Rosen's book is a detailed and comprehensive account of his own clinical research and experience with patients seen for consultation, evaluation and/or treatment under hypnosis. In it, he attempts to present an idea of the goals, scope and potentials, as well as the limitations and dangers, of this technique as it is employed in medical practice. Considerable attention is devoted to the problems of psychosomatic medicine with emphasis on the utilization of hypnosis in the differential diagnosis of emotional from organic pathology, and on the treatment of psychogenic factors which create organic difficulties or hinder recovery from medical or surgical conditions. The writer also discusses, describes and illustrates, with detailed case protocols, some of the more specialized hypnotherapeutic techniques, such as trance induction and termination, radical hypnotherapy, hypnotic unmasking, intensification and recognition of an emotion, and abreactive techniques.

The writer emphasizes that hypnotherapy, as any other form of meaningful therapy, must not be applied rigidly and automatically without an understanding and consideration of personality dynamics, interpersonal relationships and the growth or therapeutic process. Rather, as Rosen states: "We are patient, not hypnosis oriented. Hypnosis, to us, is neither a therapeutic agent nor a therapeutic technique. Patients with operable organic disease when treated surgically, are operated upon not by but under anesthetics; and patients with severe emotional disease, if hypnotized, are, likewise, to be treated psychotherapeutically not by but under hypnosis."

This book should be of primary interest and value to those interested in the theoretical or practical aspects of hypnotherapy in the various phases of clinical or medical practice. However, at least a basic knowledge of psychotherapy and hypnotic techniques is required for full understanding and appreciation of Rosen's work.

True Tales from the Annals of Crime and Rascality. By ST. CLAIR MCKELWAY. 339 pages. Cloth. Random House. New York. 1950. Price $3.00.

This is a series of sketches and personality notes, written in the brisk style of the *New Yorker* and reprinted from it. Their subjects range from Father Divine and Fire Marshal Brody, New York's chief catcher of pyromaniacs, to Harry Bridges' adventures in dodging the FBI. There is a good deal of interesting information and good sound characterization behind the bright façade of Mr. McKelway's style—and a lot of good entertainment besides.

Your Brain and You. By G. N. Ridley. xiv and 209 pages. Cloth. Watts & Co. London. 1952. Price $4.00.

In *Your Brain and You,* the author has endeavored to explain the structure, function, growth, and evolution of the human brain in a manner to be understood by the general reader. As Ridley states, "This is not a textbook. It is addressed primarily to the ordinary reader who wants to get a working knowledge of his nervous machinery without the necessity of having to cope with the technicalities which are, properly speaking, the concern of the professional neurologist."

Ridley gives a lucid and readable account of the human brain; its development and mode of functioning without, for the most part, attempting to include psychological work. Indeed, it is when the writer departs from the purely physiological aspects of the brain, and attempts to touch on psychosomatic relationships that he does appear to go astray. It seems, for example, that Ridley demonstrates a certain degree of naïveté about the fields of psychiatry and psychology when he states that, "The majority of people . . . endure hardships and dangers in war without any visible damage to their sanity. The few who crack under the strain almost always do so because they have inherently unstable minds."

Marital Infidelity. By Frank S. Caprio, M. D. 272 pages. Cloth. Citadel Press. New York. 1953. Price $3.50.

Caprio frequently writes from a psychoanalytic point of view. This volume, however, is largely on the ego level. It deals "practically," with numerous examples, with the problems brought about by marital infidelity without going into dynamics. It is a "sensible" book. As such, it is excellently adapted for counseling purposes. A clergyman called upon for advice might find it of considerable value. So might a general counselor on human relations or even a psychologist or psychiatrist who is called upon for counsel and advice rather than treatment.

The Revolution in Physics. A Survey of Quanta for the Layman. By Louis de Broglie. 310 pages including index. Cloth. Noonday Press. New York. 1953. Price $4.50.

One of the world's great physicists undertakes to write a non-mathematical discussion of atomic structure and quantum theory. It is a sound exposition of the facts for orientation or re-orientation in the basic data of science. The psychiatrist, so often accused of dealing with the intangible and the incomprehensible, will be interested in the same problem in the fundamental theories of matter and energy. Implications of the sub-title to the contrary, the "non-mathematical" nature of this survey does not make it easy reading. A good grounding in general science is a prerequisite.

Psychoanalysis and the Occult. George Devereux, Ph.D., editor. 432 pages including index. Cloth. International Universities Press. New York. 1953. Price $7.50.

George Devereux, who seems not thoroughly convinced himself, has collected and presents impartially an important series of papers on extrasensory phenomena in the psychoanalytic setting. The contributions range from half a dozen by Freud himself, through a long list of subsequently published articles, to two new contributions, by W. H. Gillespie, and Sidney Rubin, respectively, written particularly for this compilation. Of the six parts into which the material is broken down, one is devoted to what Devereux calls "the Eisenbud—Pederson-Krag—Fodor—Ellis controversy" which covers articles chiefly published in THE PSYCHIATRIC QUARTERLY.

A collection of material in this field was badly needed. This one is comprehensive, is well selected, and is excellently edited and presented. It is made up on the whole of stimulating material and it belongs in all libraries in the psychoanalytic field.

An Appraisal of Anthropology Today. Sol Tax, Loren C. Siseley, Irving Rouse and Carl F. Voegelin, editors. 395 pages including index. Cloth. University of Chicago Press. Chicago. 1953. Price $6.00.

Anthropology in its widest sense may stand closer to psychiatry than does any other strictly non-medical discipline. In this symposium of its present-day status, we find personalities well known in the psychiatric world and techniques widely employed in psychiatry and psychology. There are, for instance, six index references to the Rorschach; and there is a discussion of psychosomatic medicine from the anthropologic point of view, as well as other closely related matters. The present symposium is a survey, not only of importance to the anthropologists themselves, but of a great deal of interest and some application, to the scientist in the related disciplines dealing with man, his physical and social organization and his personality.

The Epidemiology of Health. Iago Galdston, M. D., editor. ix and 197 pages. Cloth. Health Education Council. New York. 1953. Price $4.00.

The treatment of health as a positive factor, rather than just the absence of disease, is a praiseworthy idea. But for the most part, the authors of the papers in this book seem to be at a loss for words when formulating this concept. The result is an overabundance of generalization—giving the feeling to the reader that the authors are groping toward ideas rather than expressing them.

The Madeleine Smith Affair. By PETER HUNT. 205 pages. Cloth. British Book Centre. New York. 1950. Price $2.50.

This is a new version of the much-written-up trial and acquittal of Madeleine Smith for the arsenic poisoning of her lover. The author has had access to much unpublished material which, as he states, throws little light on her guilt or innocence but considerable on her character.

There is an introduction by the famous writer on criminology, William Roughead, in which he indicates belief in the lady's guilt. After Madeleine's acquittal, in 1857, she left Scotland; was married respectably to an artist who attained prominence; had children; and eventually appears to have come to the United States where, says Hunt: "She died on April 12, 1928 and was buried as Lena Wardle Sheehy in Mount Hope Cemetery, New York. She left £13 and an Insurance Policy worth £30." The interest of this case to the criminologist and psychiatrist is, of course, obvious.

Adrenal Cortex. Transactions of the Fourth Conference. Elaine P. Ralli, M. D., editor. 165 pages. Cloth. Josiah Macy Jr. Foundation. New York. 1953. Price $3.50.

These papers are of too technical a nature to be of value to persons not members of the medical profession. As always, the participants are leaders in their fields, and they bring a wide variety of viewpoints to the conference. The complexity of the interplay of the endocrine glands in the human body is only beginning to be understood, with the far-reaching effects they can have on the physical and mental make-up of the individual. While none of the articles discussed here deals directly with the hormones' effects on personality, studies on such subjects as "Mechanisms Through Which Adrenal Cortex Can Produce Qualitatively Different Effects" can conceivably have important psychiatric implications in the future.

Society and the Homosexual. By GORDON WESTWOOD. 184 pages. Cloth. Dutton. New York. 1953. Price $3.00.

A popular treatise on homosexuality is written by a layman for British home consumption; why an American publisher should print it is unclear. The usual plea for understanding is submitted; the exaggerated Kinsey figures are taken as Bible; the author assumes that the English figures are even higher. The author is not informed about the newer psychoanalytic literature, stressing the homosexual's oral-masochistic regression. The author acknowledges, however, that homosexuality is "severe mental sickness" (p. 68), and recommends psychiatry. The book has an introduction by the British psychoanalyst, Edward Glover, which is regrettable in its superficiality. It is partly flippant, partly outdated.

Portrait of Andre Gide. By JUSTIN O'BRIEN. xii, 390 and xiv pages with index. Cloth. Knopf. New York. 1953. Price $6.00.

Here is a literary study rather than a biography, but the author recognizes that with André Gide, far more so than with many other writers, his life, his background, and his writings are interrelated.

A major segment of Gide's work consists of the reworking of classical myths, and this book treats the part each of these myths plays in his thought. While there is an attempt to explain Gide's work in relation to his own emotional problems, there is no true exploration of the dynamics involved. Using the thematic rather than the chronological approach to the study of any writer is bound to create some confusion, but in this book it is kept to a minimum. The author presupposes considerable knowledge of Gide in his reader, and this book will be found of chief value to students of literature who wish to find a comprehensive picture of the man and his work. Despite the fact that the character analysis is on a surface level, it is valuable in its own right.

Pattern for Successful Living. By FRED PIERCE CORSON. 148 pages. Cloth. Winston. Philadelphia. 1953. Price $2.50.

This is a brief inspirational volume replete with Biblical references and contemporary anecdotal exhortations. Spiritual problems of living are loosely categorized under 26 chapters and their solutions confidently found in the application of faith. Malfunction is attributed to the conscious individual, and help is seen to come from a self-willed application of Christian principles. Freud, Jung, and Adler are referred to for having "validated for current use the teachings of the New Testament." This book is easy reading, and the faithful will feel comfortably at home with it. It is not a book that will convince the patient who is struggling with religious problems.

You Shall Know Them. By VERCORS. 249 pages. Cloth. Little, Brown. Boston. 1953. Price $3.50.

A French satire on racial discrimination is written here by Jean Bruller, who previously specialized in satirical drawings, and now (under the pseudonym of Vercors) has turned writer. The plot is far-fetched: A new type of humanoid ape is discovered; to prove it is human, a journalist allows artificial insemination of a female of the new species, murders "his" British baby, and requests trial for murder. The inability to define "man," gives the author the chance to ridicule all learned institutions, including the British courts. As typical in lengthy satires, the topic is too thin for a whole book.

CONTRIBUTORS TO THIS ISSUE

LAWSON G. LOWREY, M. D. Dr. Lowrey is a New York City psychiatrist, teacher, editor and writer; he has been in private practice since 1933. He was born in Missouri in 1890. A graduate of the University of Missouri in 1909, Dr. Lowrey taught anatomy there while working for his master's degree and later was professor of anatomy at the University of Utah and assistant professor of anatomy at the University of Missouri before going to Harvard Medical School where he was a teaching fellow in histology and embryology from 1912 to 1914. He received his medical degree from Harvard in 1915, was a fellow and was instructor there in neuropathology until 1920. He was an instructor in psychiatry from 1917 to 1920 and instructor in psychology in 1919 and 1920. He became assistant and associate professor of psychiatry at Iowa in 1920. Dr. Lowrey served as pathologist at Danvers (Mass.) State Hospital even before receiving his medical degree. He was on the staff of Boston Psychopathic Hospital as first assistant physician and chief medical officer from 1917 to 1920. Before moving to New York City, where he became director of the Institute for Child Guidance in 1927, he had served with child guidance clinics in Iowa, Minnesota, Ohio and Texas where he directed demonstration clinics for the National Committee for Mental Hygiene. He is now assistant clinical professor of psychiatry at the College of Physicians and Surgeons, Columbia University, and is an associate in psychiatry at the Vanderbilt Clinic.

Dr. Lowrey was editor of the *American Journal of Orthopsychiatry* from 1930 to 1948. He is now on the editorial boards of the *American Journal of Psychiatry* and of *Pastoral Psychology*. He is author or editor of a number of books on psychiatry and mental hygiene and of about 250 scientific articles, principally on psychiatric subjects.

LUDWIG EIDELBERG, M. D. Dr. Eidelberg is a psychoanalyst in New York City and is the author of numerous scientific books and papers. Born in Poland in 1898, he received his medical degree from the University of Vienna in 1925. He is clinical associate professor at the State University of New York and is on the faculty of the New York Psychoanalytic Institute. He has been a member of the International Psychoanalytic Society since 1929. His books include *Take Off Your Mask* and *Studies in Psychoanalysis*. He has previously contributed to this QUARTERLY.

NOLAN D. C. LEWIS, M. D. Dr. Lewis' paper in this issue of THE PSYCHIATRIC QUARTERLY is, in a sense, a final report from his years as director of the New York State Psychiatric Institute, a position he held since

1936. He retired on September 1, 1953 to become director of research in neurology and psychiatry of New Jersey hospitals and agencies, a position in which he will devote his full time to research and research planning.

Dr. Lewis was born in Coudersport, Pa., in 1889. A graduate in medicine of the University of Maryland, he served in Maryland general and mental institutions as pathologist, neuropathologist and psychiatrist before going to St. Elizabeths Hospital, Washington, D. C., where he served from 1919 to 1935 as pathologist, director of clinical laboratories and finally as director of laboratories. He came to New York City in 1936 as an associate director of the Neurological Institute and was named director of the Psychiatric Institute later that same year.

Dr. Lewis is managing editor of the *Journal of Nervous and Mental Disease*, the *Psychoanalytic Review* and the *Journal of Child Behavior*, and is editor of the section on psychiatry of the Yearbook series. He will continue with his scientific editorial work and with scientific writing. He is the author of a large number of scientific articles as well as a number of scientific books.

EMANUEL F. HAMMER, Ph.D. Dr. Hammer is a New York City clinical psychologist who is at present senior research scientist in psychology on the Research Project of the New York State Psychiatric Institute. A graduate in arts from Syracuse University, his doctorate in clinical psychology is from New York University. He has served in educational, hospital and prison clinics, and came to the Psychiatric Institute from the position of senior psychologist and director of intern training at Lynchburg (Va.) State Colony. Dr. Hammer conducts the annual workshops in projective drawings (with emphasis on the H-T-P) at the Psychiatric Institute, and is a research and psychological consultant in the New York City public schools. He is author or co-author of numerous articles in the fields of social psychology, personality, child psychology, projective techniques and experimental psychopathology, and has contributed previously to this QUARTERLY.

DÉSIRÉ ANNAU, M. D. Dr. Annau received his M. D. degree from the University of Budapest in 1923. Even as a medical student, he was interested in psychiatry and served a two-year externship in a state hospital in Budapest. After his graduation, he worked on the Psychiatric and Neurological Clinics in Zurich, at Burghölzli, in Paris, at the Salpêtrière, and in Vienna until 1928, when he began private practice in Novisad, Jugoslavia. In 1935, he became head physician of the Neuro-Psychiatric Sanatorium Bethania of the American Methodist Mission; and in 1941 chief physician of the mental department of the General Hospital in Novisad. In 1944, Dr. Annau was taken to Germany with a hospital. After the liber-

ation, he became chief physician of the neuropsychiatric department of a hospital for displaced persons in Germany. In September 1949, he came to the United States and has been employed at Marcy (N. Y.) State Hospital since that time. He is author of several neuropsychiatric papers.

FRANCIS C. BAUER, M. D. Dr. Bauer received his B. S. degree from St. John's University, Brooklyn, and did postgraduate work at New York University. Following two years of bacteriology at Mt. Sinai Hospital in New York, he entered Georgetown Medical School, Washington, D. C. He became interested in psychiatry during undergraduate affiliation at St. Elizabeths Hospital and the neuropsychiatric service at Bethesda Naval Hospital. He received his medical degree from Georgetown in 1949 and after an internship of one year joined the staff at Pilgrim (N. Y.) State Hospital, where he is now a senior psychiatrist.

WERNER M. COHN, M. D. Dr. Cohn received his medical degree from the University of Berlin in 1947. After serving two years internship in this country, he joined the staff of Hudson River State Hospital and is at present a senior psychiatrist at that institution.

ALBERT E. SCHEFLEN, M. D. Dr. Scheflen is a Philadelphia psychiatrist, at present associated with Dr. Kenneth E. Appel at the Institute of Pennsylvania Hospital, Philadelphia. Born in Camden, N. J., in 1920, he is a graduate of Dickinson College and a graduate in medicine of the University of Pennsylvania in 1945. After interning in the U. S. Naval Hospital in Philadelphia, he served as a naval medical officer until 1949, both at sea and on neuropsychiatric services. He was at Worcester (Mass.) State Hospital and engaged in research at Tufts Medical College in 1950 and 1951, later going to Delaware State Hospital for a year. He is a student in the Philadelphia Psychoanalytic Institute and instructor in psychiatry at the medical school of the University of Pennsylvania, and is the author of a number of psychiatric papers, most of them dealing with insulin and geriatric psychiatry.

JOSEPH BARNETT, M. D. Dr. Barnett was born in New York City in 1926. He attended Queens College of the City of New York and later the Chicago Medical School, graduating in 1948 with a B. M. degree. He received his M. D. in 1949 after a year of rotating internship at the Ottawa Civic Hospital in Canada. He served as resident psychiatrist at Rochester (N. Y.) State Hospital from 1949 to 1951, including three months as assistant resident in psychiatry at Strong Memorial Hospital of the University of Rochester Medical School. From 1951 to 1952, he served as resident

and senior psychiatrist at Syracuse (N. Y.) Psychopathic Hospital with part-time assignment to the Onondaga County Child Guidance Center, and as assistant resident in neurosurgery at Memorial Hospital in Syracuse.

ARTHUR LEFFORD, M. A. Mr. Lefford received his training in clinical psychology at Ohio State University with further training at New York University. During World War II he served overseas in the medical department of the army. Returning from service, he taught psychology at New York University, and was assistant technical director of experimental psychology of a project of the Office of Naval Research. In 1950, he went to Syracuse (N. Y.) Psychopathic Hospital as staff psychologist, and received a Millbank Foundation grant as a research fellow for the New York State Mental Health Commission. He is at present a candidate for the Ph.D. degree, and is engaged in basic research in the relationship of perception to personality as indicated by the Szondi experimental method.

DONALD PUSHMAN, M. D. Dr. Pushman was born in Ottawa, Canada, in 1925. He is a graduate of the University of Toronto receiving his M. D. degree in 1950. He served a rotating internship at St. Paul's Hospital, Vancouver, British Columbia until June 1951. At the present time he is a resident psychiatrist at Syracuse (N. Y.) Psychopathic Hospital.

LAURETTA BENDER, M. D. Dr. Bender has been senior psychiatrist at Bellevue (New York City) Hospital since 1930 and has been in charge of the children's service there since 1934. She is professor of clinical psychiatry at the New York University College of Medicine where she has been on the faculty since 1930.

Dr. Bender is the author of a large number of papers in the fields of psychology, neurology and psychiatry, particularly with reference to children. She is a graduate of the State University of Iowa, from which she received her medical degree in 1926. She was married to Dr. Paul Schilder in 1936; he died in 1940.

NEWS AND COMMENT

HUTCHINGS MEMORIAL AWARD STILL OUTSTANDING

The $100 special memorial award to be made by the Richard H. Hutchings Memorial Committee for an outstanding contribution to psychiatry from a public mental institution is still pending. The award is presented by an anonymous donor through the late D. Charles Burlingame, M. D. psychiatrist-in-chief of the Institute of Living, Hartford, Conn., who was a member of the Hutchings Memorial Committee.

The award, offered some four years ago, is to be awarded by the memorial committee at a time within its discretion. The committee has felt up to this time that there have been insufficient nominations and more would be welcomed now. The award is without restriction as to type of professional achievement; scientific articles, reports or nominations for the award should be submitted to the chairman of the memorial committee, Dr. Harry A. Steckel, Suite 1804, State Tower Building, Syracuse 2, N. Y.

The award is open not only to members of the New York State hospital system but also to those of other states and to workers in federal and local institutions.

The fifth annual Hutchings Memorial Lecture, conducted under the auspices of the memorial committee, the Onondaga County Medical Society, the Syracuse Academy of Medicine, and the College of Medicine, Syracuse University, was given on October 5, 1953 by Bernard C. Glueck, Jr., M. D. Dr. Glueck, who is director of the Sex Offender Research Project of the New York State Department of Mental Hygiene and is supervising psychiatrist at Sing Sing Prison, spoke on "Psychodynamic Patterns in the Sex Offender." His lecture will be published in this QUARTERLY.

Dr. Hutchings, in whose memory the lectures are being held, died in October 1947 after an outstanding career in psychiatry. He had been superintendent of both Utica and St. Lawrence (N. Y.) State Hospitals, had been president of the American Psychiatric Association, and was editor of THE PSYCHIATRIC QUARTERLY at the time of his death. He was professor of clinical psychiatry for many years at the Syracuse College of Medicine where the annual lectures are held, and teaching was one of his life-long interests. His best-known publication is in the teaching field, *Psychiatric Work Book*, a manual for students and practitioners of medicine, nursing, psychiatric social work and allied disciplines.

LEWIS LEAVES INSTITUTE AFTER 17 YEARS

Nolan D. C. Lewis, M. D., director since 1936 of the New York State Psychiatric Institute, retired on September 1, 1953, to become director of re-

search in neurology and psychiatry of New Jersey hospitals and agencies. He plans to devote his entire time to research and research planning and will continue writing and editing. Brief biographical notes on Dr. Lewis' career appear under the heading "Contributors to This Issue" on pages 718 and 719 of this QUARTERLY.

In other important changes among the personnel of the New York State Department of Mental Hygiene, Raymond G. Wearne, M. D., director of Wassaic State School since 1937, retired on July 1; and Richard V. Foster, M. D., director of Gowanda State Homeopathic Hospital since 1951, was appointed to a new position as an assistant commissioner of the department on April 15.

NEW INTERNATIONAL PSYCHIATRIC JOURNAL IS ANNOUNCED

A new quarterly, *Acta Psychotherapeutica, Psychosomatica, Orthopaedagogica,* has been announced for publication in Leyden, the Netherlands, with the first issue to appear in January 1954. It will publish original articles in French, German and English; and American editors are Franz Alexander and Flanders Dunbar. Chief editors are E. A. D. Carp and B. Stokvis, both of Leyden.

A new annual in the mental hygiene field will appear in January with the first issue of the *Annual of Pastoral Psychology.* It will be published by the monthly journal, *Pastoral Psychology,* and will be, says the publishers' announcement, "devoted entirely to a listing of significant reference and resource material for the minister, clinical psychologist, psychiatrist, and all other workers in the field of human behavior."

INTERNATIONAL CONGRESS TO MEET IN ZURICH

An international congress for psychotherapy has been announced for Zurich from July 21 to July 24, 1954, under the auspices of the Swiss Medical Association of Psychotherapists. The subject will be "Transference in Psychotherapy"; and attendance is open to psychiatrists and psychotherapists who are members of national professional associations or recognized societies, and to others properly recommended.

The International Association for Child Psychiatry will hold a two-day international institute in Toronto on "The Emotional Problems of Children under Six," August 12 to 14, 1954 in connection with the Fifth International Congress on Mental Health. Professional workers of all disciplines concerned may attend, and the association invites clinical case studies for presentation and discussion.

The First International Congress on Group Psychotherapy is also scheduled for Toronto from August 12 to 14. The membership of the sponsoring committees, it is announced, includes representatives "of all varieties of

group psychotherapy, without distrimination." Representatives from 17 nations are sponsoring the meeting.

The First Latin-American Congress on Mental Hygiene will be one of 10 scientific congresses to be conducted in São Paulo, Brazil, during July 1954, in observation of the fourth centenary of the city of São Paulo. It will be sponsored by the São Paulo Medical Association.

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IS YOUR HOUSE HAUNTED?

A mental health booklet, *Haunted House,* dealing in simple language with the problems of fear, worry and anxiety, has been issued by the New York State Department of Mental Hygiene and is available for distribution by agencies and organizations interested in the promotion of mental health. Illustrated by Joe Musial, and with the brief text by Margaret Farrar, the booklet is printed in two colors. The cover is a replica of the Haunted House exhibit which the Department of Mental Hygiene presented at the New York State Fair in Syracuse in September 1953. Commissioner of Mental Hygiene Newton Bigelow, M. D., was psychiatric adviser for the publication.

Copies are free to New York State agencies and organizations interested in its distribution, and single copies are free to anybody anywhere. Requests should be addressed to the New York State Department of Mental Hygiene, Albany, N. Y.

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NEW POSITIONS ANNOUNCED BY DEPARTMENT

New research and administrative positions were announced by the New York State Department of Mental Hygiene during the spring and summer of 1953.

Charles I. McAllister of West Hempstead, supervisor of the New York City public school program for children with retarded mental development, was named on September 16 as supervisor of education for the Department of Mental Hygiene. The position is a new one and Mr. McAllister's duties will cover development of the academic program for children in state schools for mental defectives.

In a special research appointment, Dr. Bjorn Vestergaard, Danish psychiatrist, was named to the staff of the research project headed by Dr. Nathan S. Kline at Rockland State Hospital. He will serve with the title of research scientist, as an assistant to Dr. Kline.

In another departmental educational development, some 200 first-year nursing students of the Department of Mental Hygiene enrolled in the freshman classes of New York State colleges and universities in September. The affiliation of department schools with institutions of university grade began three years ago. It was expanded this year to include eight such institutions.

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